

THE OVERLAPPING PHENOMENOLOGY OF AUTISM SPECTRUM DISORDER AND THE ENDURING  
EFFECTS OF EARLY ATTACHMENT EXPERIENCES: AN EXPLORATION OF EDUCATIONAL  
PSYCHOLOGISTS' PERSPECTIVES AND PROBLEM ANALYSIS PROCESSES.

by

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## **ABSTRACT**

This study explored the perspectives and practices of Educational Psychologists (EPs) who had encountered the apparent overlapping phenomenology of autism spectrum disorders and the enduring effects of early attachment experiences in their casework.

Six EPs from across two Educational Psychology Services in the North East of England, took part in individual interviews, which were audio recorded and transcribed. Inductive and deductive analyses were mediated through the active constructionist role of the interviewer during the iterative interview process and the thematic analysis of the resultant interview transcripts. The study intended to focus on exploring EPs' differential conceptualisations of autism and attachment and on how they conceptualise and attempt to differentiate the overlapping phenomenology. Analysis identified two other dimensions, however, which complemented the planned foci in a cogent way and were also examined: how EPs conceptualised the value of differentiating between autism and the effects of poor early attachment experiences; and how the discipline of educational psychology offers a distinct contribution to problem analysis in this area. The talk of EPs captured in this study contributes to existing practice-based evidence about overlapping phenomenology, and by describing a process of psychological problem analysis which could support more reliable differentiation between autism and effects of poor early attachment experiences. A distinctive contribution of the discipline of educational psychology is proposed and suggested as worthy of closer consideration as ethics and efficiencies are both of legitimate concern in contemporary multi-disciplinary, public service contexts. Other implications identified from this study pertain to the way in which EPs articulate their relationship with theory, their use of practice frameworks, and the distinct nature of their identities.

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## **CHAPTER 1**

### **INTRODUCTION**

#### 1.1 Aims of chapter

This chapter does a number of things. It:

- introduces the aims of the current study;
- addresses issues of identity;
- gives an explanation of the terms used in this thesis;
- explains the academic and professional practice perspectives informing the current study;
- introduces the national landscape in terms of relevant policy; and
- provides a brief description of the structure and organisation of the thesis.

The following sections will take each of these in turn.

#### 1.2 Aims of the current study

The aim of the current study was to explore the perspectives and problem analysis processes of educational psychologists (EPs) in attributing meaning to the overlapping phenomenology of autism spectrum disorders and the enduring effects of early attachment experiences. Planned research questions were directed toward constructing EPs' accounts of autism and attachment and their problem analysis processes. Analysis of interview data subsequently led to the consideration of other particularly relevant dimensions: the value of trying to differentiate autism from the effects of poor early attachment relationships in itself and the specific identity or skill set of EPs in this domain.

My study sought to generate an interpretative, and therefore an intersubjective form of understanding of the practice of EPs within the focus domain, and the factors influencing their practice.

### 1.3 Issues of Identity - "Know thyself"

Working from the premise that all research is value-laden (Silverman 2011, p6), and that understanding a phenomenon engages the self, which is culturally and historically informed, and will inevitably shape the meanings that are available to me in the world of research, it is important to articulate my identity as the researcher. In this introduction therefore, I provide some information about my identity as the researcher, so that the reader is oriented to my position in relation to the study that is detailed in this thesis (Willig 2001).

By training and professional qualification, I am an educational psychologist. Since beginning the post-qualification doctorate programme, aspects of my private identity have evolved. I have, in a therapeutic context, explored aspects of self, such as being someone who was fostered before being adopted as an infant and who experienced the care system as an adolescent. I am now married and a parent, and have established that I have a relative with a diagnosis of autism. Attachment experiences and autism are both, therefore, of personal significance, although the significance was beyond my awareness at the time of beginning this course of study and becoming interested in this topic area.

Over the same time frame, aspects of my professional identity have also evolved. I have held the posts of main grade and senior practitioner EP in one local authority (LA) (LA 1) and specialist senior EP with a focus on Autism Spectrum Disorders in a second (LA 2). EP participants for the current study were recruited from LA 1 and LA 2. I was working in LA 2 at the time of conducting the research interviews. The nature of our researcher-participant identities, therefore, was complex, and included: colleague, former colleague, and ex-tutor. I am now principal educational psychologist in another local authority (LA 3). All of my EP experience has been in the north-east of England. I am

situated as a practising EP who is engaged in research as part of an academic endeavour, not a full time researcher.

At the time of applying for a place on the Doctorate programme 10 years ago, my referee wrote that “at that point in (my) development” my comfort zone was with “truths, what was real and with certainty...black and white thinking, getting ready to move towards uncertainty, a version of the truth, a version of reality, and accepting shades of grey”. My journey during the intervening years has led to the decision to adopt a constructionist approach to this final part of my Doctorate programme.

#### 1.4 Defining Terms

This thesis uses a variety of terms interchangeably. Autism and Autism Spectrum Disorder (ASD) are terms used to refer to a whole range of diagnostic classifications that are considered part of the autism spectrum as defined within classification systems adopted by both the Diagnostic and Statistical Manual (DSM 5) (American Psychiatric Association (APA), 2013) and the International Classification of Diseases (ICD 10) (World Health Organisation (WHO), 2010). Similarly, the term ‘attachment’ is used in this study to refer to attachment ‘problems’, ‘difficulties’, ‘patterns’ or ‘themes’. The current study does not use the term ‘attachment’ to refer to diagnoses of Attachment Disorders as defined in diagnostic classification systems. The choice of terms is at times for grammatical or linguistic fit. Where volunteers’ accounts are quoted, their terminology is retained.

#### 1.5 Determining the research interest

I endeavour to demonstrate that there are legitimate grounds for the current study. These grounds are of an academic perspective, founded upon consideration of relevant theoretical, research, policy

and professional literature, and a professional practice perspective, informed by experiences whilst working as an EP.

The process of coming to this research topic was not a linear, 'scientific' process of scholarly engagement with a literature base. The process of arriving at the research topic of the current study is better encapsulated in these ways:

"The history of inquiry begins with something that is less than a problem...It may be considered as an awareness that there is a question to be asked, without anyone being able to frame the question successfully" (Ravetz 1971, p135).

" Only a tiny fraction of all knowable facts are of interest to scientists...this appreciation [of what is of interest] depends ultimately on a sense of intellectual beauty...an emotional response" (Polanyi 1974 p 135 , cited by Mellor, 2009).

The research interest for the current study arose from practice experiences, which repeatedly presented themselves over time and across diverse contexts, strengthening my professional interest and curiosity. Encounters in practice were experienced over the course of a number of years prior to beginning the research and are still encountered, a decade on; they occurred during my practice in both my generic, specialist and leadership EP roles. Such experiences, across sites, across roles, and across time made a personal-professional impression that a 'phenomenon existed' that was worthy of study.

My interest in the specific question of whether an individual's presentation is better interpreted as attachment or autism- related, began when I worked as a main grade and then senior practitioner EP. I heard other EPs make comments like, "It looks more like attachment than ASD", and remember being captivated and wanting to understand what they meant more fully. I also had direct experience in my own generic, school-based casework, of generating alternative hypotheses about a child / young person's presentation, and in particular, whether a presentation would be better interpreted within an autism or attachment framework. I can recall listing the presenting features and trying to conceptualise how these aligned with effects of autism and/or attachment difficulties.

When the time allocation model for the EP Service (LA 1) was reviewed, I was able to increase my contribution to the local multi-agency autism assessment team. This provided the opportunity to develop my skills in noticing behaviours that could be considered evidence of Autism. Through that work, and alongside this personal reflection, my initial interest was encouraged. I continued to be aware that other colleagues encountered similar challenges in their casework. I felt a desire to engage with others intellectually, and was disappointed and frustrated that there appeared little opportunity for these judgements to be discussed and/or coherently resolved.

I then moved to LA 2 to take up a specialist senior EP (SSEP) post, with a focus on autism. The role was more 'strategic', as opposed to being 'the EP' directly assigned to work with every child with autism. As part of this role, I became the educational psychology team's representative on the local multi-agency autism assessment team. This represented something of a 'step up' from my previous autism- related work at LA 1 and entailed a more direct role in 'deciding' whether a diagnosis of autism was appropriate. By way of handover, I shadowed the outgoing EP representative. When the first child on the agenda was discussed, I heard the same comment as I had previously, this time by a Speech and Language Therapist, "It looks more like attachment!" Again, however, no account of how or why this interpretation was offered followed.

That statements and situations like this had been observed over time (spanning some seven years), across settings (two different local authorities and different settings), and by at least two different professions, in addition to my own reflections, led me to judge that this was a topic substantial and worthy of more systematic study / investigation than had been afforded to date by my private musing!

On a personal level, my search for my birth family led me to discover that I had a half-sibling with autism. The idea that autism runs in families, made me start to reconsider the 'Aspie' jokes

sometimes made about my character. The question of how to tell attachment-related behaviour apart from autism-related behaviour became of increasing interest on a personal level, and had not lost its original fascination on a professional level.

Moving from this professional practice perspective to an academic perspective, a review of the literature revealed that this area of study was not only of legitimate interest, but viable from theoretical, policy and academic perspectives too. Discrete searches into autism and attachment yielded a vast range of literature bases concerning theories about their causal nature, descriptions of observable characteristics, and practical suggestions for management and intervention. The literature review chapters will speak to pertinent aspects of that literature base in more detail.

Of particular relevance to the current study is the literature reporting the practice of differential diagnosis by clinicians. For example, discriminating autism from developmental delay in the early years, or differentiating autism from severe learning difficulties in later stages of development into adulthood. There is also a literature base about the presentation of attachment behaviours and effects of poor early attachment in individuals with autism. The research and literature concerning the differential decision-making of clinicians is small in proportion to the sheer volume of autism-related literature. Existing documents such as the Coventry Grid (Moran, 2015) and Appendix K of the National Institute of Clinical Excellence (NICE) Guidelines (NICE, 2011) provide descriptions that could be used at the point of diagnostic decision-making. Those documents do not, however, suggest a process of professional activity at the earlier, 'pre-diagnostic' stages of casework. Whilst good practice guidelines (NICE 2011) emphasises the importance of multi-agency contributions toward reliable autism assessment pathways, existing literature speaking to the activity or process of an individual discipline in this specific arena is limited. Put another way, there is yet to be a paper concerning itself directly with the topic of EP practice in relation to the difficult task of untangling the presentation of an autism spectrum condition from the enduring effects of an attachment pattern. I would suggest, therefore, that my research interest is legitimised by gaps in the research

literature which existed at the time I began this research in 2010. I suggest that this study makes an original contribution because it concerns itself with endeavouring to address this identified gap in existing research and because of its iterative and social constructionist approach to exploration.

#### 1.6 National and local context

Attachment theory has developed considerably since Bowlby's (1969) early ideas. In England, the applications of attachment theory have been diverse within the broad arena of children's services (Sutton Trust 2014). A good practice clinical guideline has been published relatively recently (NICE, 2015). Meanwhile, autism has been moving with unparalleled momentum. Autism is the first Disability to become subject of legislation via the Autism Act (2009). The subsequent adult strategy, Fulfilling and Rewarding Lives (DoH, 2010) sets a clear framework for all mainstream services across the public sector to work together for adults with autism. Clinical guidelines have also been developed for the recognition, referral, and diagnosis of autism in both children or young people and adults (NICE, 2011 and 2012 respectively) and further guidelines were published in 2013 (NICE 2013). Services speak of being 'NICE-compliant' if they meet the recommendations outlined within them.

There has been however, a national and international furore in response to the latest edition of the Diagnostic and Statistical Manual, DSM 5 (APA, 2013), one of the two internationally recognised diagnostic classification systems. Concerns are varied and include issues of reliability, a broadening of criteria, cancellation of field testing steps, and the relationship between task force members and the pharmaceutical industry (Frances, 2012). In addition, with a definitive 'medical test' for autism 'some way off', clinicians remain dependent on evaluating the match between manifest phenomenology and the listed diagnostic criteria: it remains the case that autism diagnosis is dependent on clinical interpretation of observable behaviours. Of specific interest to this study, is the fundamental question of whether / how reliably, when some behaviours (or phenomenology)



are considered indicative of both autism and attachment difficulties, practitioners differentiate one from the other.

The NICE Guideline (2011) includes an Appendix (Appendix K) outlining differences between autism and other disorders, which include attachment difficulties, to help clinicians interpret behavioural observations at the point of diagnostic assessment. Moran and colleagues (Moran et al 2010) have devised and revised (2015) the 'Coventry Grid', outlining differences between autism and attachment in particular. These supportive documents provide accounts for use at the point of differential diagnosis, and there is a literature base about similarities and differences between and within these two conditions. There has been, however, little research exploring professionals' decision-making processes and experiences at earlier points in the referral process. In particular, the debate about the nature of the EP role in this arena is yet to be reported.

At a local level, diagnostic services for children and young people have been multi-agency in make-up, and have been operating informally, without the acknowledgement that substantive commissioning was required. This was at odds with the regional picture for adults, who, thanks to the Autism Act (2009), had benefitted from an established and formally commissioned adult pathway. The local diagnostic service been the focus of much of my work for an extended period (February 2010 until August 2013), as practitioners and families laboured to draw attention to the need for a formally commissioned diagnostic pathway for children and young people. Educational psychology services in the region had been playing an integral role in contributing towards, and in some cases running, 'good will' multi-agency services to enable diagnostic assessments to continue. However, the government deficit reduction programme (or austerity programme comprising a series of sustained reductions in public spending) was initiated in 2010 by the Conservative and Liberal Democrat coalition government. Following cuts to local authority funding from central government a number of local EP Services made staff redundant and remaining staff were re-positioned to focus

on the statutory responsibilities of the LA. National austerity measures had local implications therefore, which coincided with local Commissioners interpreting NICE Guidelines to place the responsibility for diagnostic services within Child and Adolescent Mental Health Services, whilst pressing local authorities to fund contributions from Educational Psychology Services. In the context of reduced local authority budgets, EP contributions to diagnostic pathways have largely ceased within a number of areas across the region.

Autism is 'enjoying' a high profile and the apparent increase in diagnostic rate is sometimes described as being of 'epidemic' proportions (Goldberg 2011). Commissioners and practitioners want to ensure that referrals for multi-agency assessments are appropriate, arguably for different reasons; to keep costs reasonable; to keep family expectations realistic and to practise safely and ethically for children. The landscape sketched here suggests that my proposed study is both topical and necessary.

### 1.7 Organisation of thesis

The contents of three literature review chapters are organised around the main concerns of this study. Chapter 2 considers literature relating to conceptualisations of autism, in terms of its origins, and nature. Chapter 3 considers the development of attachment theory, the implications of insecure attachment patterns and consequences of maltreatment, in light of the overlapping phenomenology which is taken to be indicative of both autism spectrum conditions, and effects of poor early attachment relationships, particularly if these were characterised by maltreatment and / or neglect. Chapter 4 focuses upon the diagnostic, and differential diagnostic processes that may be used to discriminate reliably between autism and the effects of early insecure attachment relationships, giving particular attention to the problem analysis processes upon which educational psychologists (EPs) commonly draw in their own contributions toward assessment and formulation of children's needs. Searches were made via the databases available to the e-library facility of the University of

Birmingham, EBSCO and internet. Key Words used in the literature searches were autism, attachment, diagnosis, differential diagnosis, attachment and autism, and problem analysis. Literature was selected for consideration based on relevance to the core interest of the study, as described above, those illustrating the historical development of theory over time and those providing a contemporary perspective. Two methodology chapters explain the conceptual considerations influencing the design of the study (chapter 5) and detail the methods of data collection and analysis (chapter 6). Chapter 7 presents the findings of a thematic analysis. Chapter 8 offers concluding remarks about the findings and the strengths and limitations of the study. Appendices provide information to aid transparency of the process undertaken and to provide an audit trail of the claims that are made.

## **CHAPTER 2**

### **LITERATURE REVIEW: AUTISM**

#### 2.1 Chapter Outline

This chapter presents the theoretical developments pertaining to the origins and nature of autism. How autism is diagnosed and issues of differential diagnosis, as also pertinent to the research questions of this study, are addressed in Chapter 4.

#### 2.2 Terminology

Kanner (1943, Cited Baron-Cohen, 2008)) an American (Ukrainian born) psychiatrist is credited as being the first to identify autism as a condition separate from other mental health classifications of the time. Kanner's description of autism has been known as Kanner's autism, infantile autism, and subsequently autistic disorder. Asperger (1944, Cited Frith, 1991) an Austrian born doctor identified 'autistic psychopathy', a pattern including "a lack of empathy, little ability to form friendships, one-sided conversations, intense absorption in a special interest, and clumsy movements." Asperger called these children "little professors" because of their ability to talk about their favourite subject in great detail. Both agreed that what they were studying was a unique and different developmental disorder that had not been clinically described before and that individuals were unjustly considered 'mentally handicapped'. After Kanner and Asperger, the work of Lorna Wing (1979), an English Psychiatrist who had a daughter with autism, has been considered influential in shaping the current understanding of autism. She coined the term 'triad of impairments' (or three core areas of difficulty) and introduced the idea of a 'spectrum' or related disorders, both of which continue to be widely accepted ways of understanding the nature of autism. Kanner's classic autism and Asperger Syndrome have been seen as part of a group of conditions commonly known as autistic spectrum disorders or autism spectrum conditions. Infantile Autism was introduced into the Diagnostic and Statistical Manual (DSM) in 1980, which became autistic disorder in 1987, and Asperger's Disorder was included in 1994. Asperger's has now been removed as a classification from DSM 5 but remains

for the time being in ICD 10, as Asperger Syndrome. From here onwards, I will use the term autism as a shorthand for referring to all conditions currently described within DSM 5 and ICD 10 under the broad heading Pervasive Developmental Disorders, unless referring specifically to purported subtypes.

## 2.3 Aetiology of Autism

This section introduces the reader to different conceptualisations of the causes of autism. Three superordinate models are presented, biological, psychogenic and social model, to illustrate the divergence of existing perspectives. These subsections highlight that understanding the causes of autism could be best described as a work in progress.

### 2.3.1 Biological models

Despite the extensive research base, there remains no clear-cut answer to the question, ‘What causes autism?’ Autism is, however, often referred to as a neurodevelopmental disorder (National Autistic Society, 2013). Baron Cohen (2008) neatly synthesised large volumes of diverse research into the theories of Autism. He explains how earlier purely psychological theories of autism have been surpassed by a ‘large body of biomedical research’, which has used brain-scanning techniques to discover a larger than average head and brain size in the early years of development and differences in brain structure, activity (in regions associated with social functioning), blood flow and levels of neurotransmitters. He summarised,

“There is no longer any doubt that autism spectrum conditions are biological in origin. The strongest evidence supports the genetic theory. Heritability of autism and Asperger syndrome is not 100 per cent. This means that there must be some environmental component too, in all likelihood interacting with the risk genes. We do not yet know what the environmental factors are. There is not yet a biological marker with which to diagnose autism spectrum conditions, but research into the biomedical aspects is being accelerated. Evidence points to atypical brain development pre- and post-natally, particularly affecting processing of social information” (p 85).

In support of the heritability hypothesis, Ozonoff et al’s (2011) prospective longitudinal study of infants at risk for autism was conducted using a ‘multisite international network’. They found that

the sibling recurrence rate of autism is higher than had been estimated by other studies. The size of their sample (n=664) and the prospective nature of data collection, they felt, minimized many limitations of earlier studies of sibling recurrence.

Findings from twin studies however, whilst pointing also to the heritability of autism, at the same time suggest the presence of non-heritable, prenatal and perinatal risk factors (less than 70% of twin pairs are concordant for autism) (Bailey et al 1995). A “strong genetic component” had been identified as early as 1977 (Steffenburg et al 1989, cited Lauritsen et al, 2005) but the “mode of inheritance appears to be complex and a polygenic model with interaction of 3 to more than 15 genes has been suggested”. Lauritsen et al (2005) point out that despite decades of study, “the specific aetiology remains unknown”. Lauritsen’s large sample size of almost 1 million children born over a 7 year period in Denmark and followed up longitudinally concluded only that the highest risk factor for autism was the presence of autistic disorders within the family, supporting an ‘accepted knowledge’ that genetic factors are involved in the aetiology of autism.

Freitag (2007) explains the complicated methodological issues that limit our ability to draw resounding conclusions of biological factors: small sample sizes (so lack of statistical power to detect meaningful differences) and the use of clinical samples rather than epidemiological samples so prone to selection bias and ‘aggregated scores’ of perinatal and obstetric conditions. Freitag concludes that article by suggesting that autism is a predominantly genetically determined disorder and hopes that future studies with new technologies and larger sample sizes (with higher statistical power) may lead to more stable results.

On the ‘environmental’ factors, and attempting to address the methodological limitations of much research, Kolevzon et al (2007) reviewed and integrated findings from 7 epidemiological studies identified through database searches. Studies included covered California, Denmark, Sweden, Israel, and Western Australia. Parental characteristics associated with increased risk of autism were

advanced maternal and paternal age. Obstetric factors associated with increased risk were foetal growth restriction and intra-partum hypoxia (for a variety of reasons). These were not proven as risk factors but suggested as areas to continue to be examined in future studies. They state that as of that time, there were no identified genes for autism.

A more recent UK study (Ronald et al 2010) used a large twin based methodological design to go beyond looking for an association and to explore the extent to which the relation between neonatal problems and autistic like features might be due to common genetic and environmental influences. That study found support for a weak association between pre and neonatal events and later autistic like features in the general population.

Gardener et al (2011) undertook the first meta-analysis and review of the association between perinatal and neonatal factors and autism. 40 studies and over 60 perinatal and neonatal factors were examined. They produced a list of factors associated with autism risk but their analysis did not provide sufficient evidence to suggest causation. They concluded that there was sufficient evidence to suggest that exposure to a broad class of conditions reflecting general compromises to perinatal and neonatal health may increase the risk of autism.

Mamidala et al (2013) conducted the first ever study of risk factors associated with autism in India. They used a large retrospective cohort (nearly 1000 children) from across 8 cities to examine prenatal, perinatal, and neonatal risk factors. Prenatally, advanced maternal age, foetal distress and gestational respiratory infections were associated with autism. Perinatally and neonatally, labour complications, pre-term birth, neonatal jaundice, delayed birth cry and birth asphyxia were associated with autism.

Taking a closer look at what constitutes 'environmental' risk factors in these kinds of studies, what is found is a focus on 'biomedical phenomena' around gestation and delivery, rather than the

‘environment’ days, weeks or months, post-partum... i.e. what many would call ‘environmental’ (food, drink, medication, parenting practices). One aspect yet to be conclusively unravelled is whether existing genetic vulnerabilities cause the peri and pre-natal complications to arise or whether pre and pre- natal complications ‘trigger’ the genetic vulnerability. A causal relationship is not determined, only an associative relationship has been identified to date.

Others remain sceptical about the genetic contribution to autism spectrum. In the States, Goldberg (2011) with nearly two decades of experience of neuro-immune dysfunction syndromes, reflects that the prevalence rate of autism in 1956 was 1 in 10,000 yet was around somewhere between 1 in 80 to 1 in 110 in 2011. He describes this increased prevalence as an increase of epidemic proportions, yet never has there been an epidemic of any type of genetic condition. He asks the question, how can so many children now have such a previously rare disorder? Part of the problem muddying the research (and intervention) waters, in his view, is that,

“It is blatantly obvious that 99.9 per cent of affected children [these days] do not come close to meeting Kanner’s definition of autism” (p30).

Goldberg states that the initial diagnosis has continued to expand and modify to become ‘an alphabet soup’ (PDD, Asperger’s, Autism, Landau-Kleffner etc.) of autism and that, many children would fail to meet Kanner’s main criteria of a ‘profound lack of affective contact and elaborate, repetitive ritualistic behaviour’. The argument is that the apparent increase in diagnosis is not due to changes in genes, but a manifestation of broadened classification criteria. Goldberg is not complaining about the straying from Kanner’s initial criteria per se. but it is central to the argument he goes on to make. His theory is that the broadened Kannerian definition has been erroneously applied to populations who might actually be experiencing something altogether quite different: a neuro-immune dysfunction syndrome. Again in the States, Herbert (2012), a Harvard neurologist, also has an alternative view of the causes of autism to a straightforward ‘genes-hopelessly-mess-up-the-brain-for-life’ model of autism (p6). She describes that,



“Geneticists have been searching for autism’s “smoking gun” for more than a decade. But though more discoveries are on the way, so far they have identified genetic “defects” in only a small minority of people with autism – leaving the vast majority of cases of autism genetically unexplained...By now, most researchers agree that genes don’t usually act on their own to cause autism. Genes may lead to vulnerability – they may “load the gun” – but so much of the time, its environment that “pulls the trigger” (p6.)

Herbert echoes Goldberg’s refutation of genetics being solely responsible, and speaks of the impossibility in fact on account of,

“Genetics cannot explain the rising frequency of the condition. When I first got involved in autism research in 1995, people thought that 1 in every 3,300 children had autism. As I write that figure is approaching 1 in 100. Genes take generations to evolve, so either we have been oblivious to autism, or something other than genetics is causing autism more often” (p7).

Herbert does not think ‘we’ have been oblivious to autism, or that we have become increasingly adept at diagnosis. She continues to note that research looking into genetics has found, not one single gene, but hundreds of genes, each of which only accounts for only a small number of people with autism diagnoses. Herbert describes her theory of Autism as a ‘whole body approach’. This includes advocating for genetic testing but she also believes that environmental risks can shape gene expression. Differently to the environmental factors in other existing research described in this thesis, she refers to ‘food, toxins, bugs, and stress’,

“Autism emerges from an interconnected web of accumulated problems and emerges when the total load of difficulties exceeds what [your] child’s brain and body can handle” (p219).

Frith (2008) agrees that “multiple genes are most likely to play a part” (p55) but disagrees that environment (“an adverse environmental event after birth”, p44) is likely to cause autism.

### 2.3.2 Psychogenic models

Whilst Baron Cohen confidently stated in 2008 that psychological theories, such as Bettelheim’s ‘refrigerator mother’ theory (autism is caused by a lack of maternal warmth) (Bettelheim, 1967, cited Bogdashina, 2006), have been surpassed by biomedical research, it is not clear that this

position is universally embedded and that the 'ditching of psychogenic theories' is by no means a position adopted globally.

A very different perspective of autism is revealed in the early pages (3-5) of Barrows et al (2008) who write from the psychoanalytic tradition. On the causes of autism, they write,

"increased psychoanalytic understanding of childhood autism has expanded our understanding of primitive levels of the human psyche. The fears of bodily and mental catastrophe which can underlie autistic defences..... the understanding of childhood autism has a lot to contribute to work with those adult patients who employ autistic defences in order to cope with their anxieties" (p3) and "It [Asperger Syndrome] was thought by Tustin (1994b) to derive, like autism, from a catastrophic experience of separateness, but at a later stage of development, after the acquisition of language" (p4).

On the possibilities for intervention, they write,

"The need for early intervention in childhood is usually critical if the autistic state is not to become permanently entrenched. It is certainly the case that the earlier autistic spectrum disorders can be diagnosed and treated, the more hopeful the outcome" and "in cases of early autism the infant may be enabled to come out of a state of autistic withdrawal and be freed to develop" (p5).

Barrows et al (2008) also refer to colleagues in Caen, Normandy, France, using an 'intensive infant observation approach to treat dysfunctional interactions between mother and infant'. Some concordance with Bettelheim's supposedly surpassed theory is therefore visible:

- relationships and interactions are the cause of autism;
- observable symptoms are reactions to events; and consequently
- autism is treatable.

It is clear that this conceptualisation is diametrically opposed to biological conceptualisations, either genetic or interactionist.

A press article from Chantal Sicile-Kira (2011) a US journalist, and now author, consultant, advocate and founder of AutismCollege.com, who had lived in France with her autistic son, does a number of

things. It describes excerpts from a film (The Wall) which highlighted “the treatment [psychoanalysis] that families are offered in France when seeking help for their child with autism”. It refers to the political power psychoanalysts have enjoyed in France even in the face of a lack of evidence for treatment effectiveness (including French psychoanalysts trying to ban the film). She relays her own experience of psychoanalysis as the predominating approach to autism in France at that time. Some excerpts from her article are provided next to illustrate what is meant by a psychogenic conceptualisation,

“The documentary consists of interviews of 30 French psychoanalysts (many of them lead psychiatrists at treatment centers and department heads of notable French hospitals) who place the blame for autism on mothers who are either too cold or too incestuous towards their children. The psychoanalysts in the film quote Bruno Bettelheim (a proponent of the "refrigerator mother" theory of autism), Sigmund Freud (father of the Oedipus complex and penis envy), and Jacques Lacan when discussing the causes and treatment of autism. In the 1960s, Lacan described psychotic and autistic children as victims of the alienation of a psychogenic mother who is unable to separate from a child who is a substitute for the penis she was born without... In the first interview shown, a psychoanalyst explains that when treating a child with autism, toy crocodiles with their large mouth full of sharp teeth represent mothers wanting to eat their young, and that a phallus symbol representing the father (in this case a pen) needs to block the mother's mouth to keep her from devouring her child... my autistic son Jeremy (now 22) was born in France. When I sought help for him, I was told that in order for him to continue to receive services such as speech and language therapy, and psychomotricity (both of which helped him), then he had to see a psychoanalyst. We stopped treatment after three sessions. During the third session (luckily my husband was there as a witness) she began to question me about how Jeremy had reacted when I stopped breastfeeding because Jeremy was stimming with a salt and paper shaker set (two round objects). When one of the objects fell to the floor she cried "He has lost his mother's breast!" and when he went looking for the object she exclaimed "he is searching for his mother's breast!" That was enough for my family and that was the day we decided that we had to leave France to get any educational and useful help for our son...”

Despite the Council of Europe “condemning France in 2004 for not meeting its obligations to provide children with autism an appropriate education” (Sicile-Kira, 2011), it is only as recently as 2012 that the High Health Authority in France has recommended educational and behavioural approaches to Autism, rather than psychoanalysis. Families, like the author of this article, who had rejected this ‘treatment’, and refused their children entry into psychiatric facilities had been previously pursued for neglect in child protection procedures (David 2012, p22-23).

### 2.3.3 The Social model

Molloy et al (2002) write that the social model of disability is often misunderstood as meaning that disabilities<sup>1</sup> do not exist and they address this erroneous interpretation,

“this model challenges the medical model’s view that disabilities are caused by physical entities that exist in the world, and instead posits disability as an interpretation of physical differences by discourses invested by social and political power” (p662).

Whilst the social model agrees with the medical model that impairments and illnesses exist in the world, it acknowledges that how these illnesses and impairments are classified, treated and interpreted is socially constructed (p 662). The model makes a distinction between the impairment (the lack of a limb, for example) and the disability (the disadvantage that results from social organisation that takes no account of people who have physical impairments) (p662-663). This article takes the construction of the category of Asperger’s to task. It does this by suggesting a number of things: that it serves those in the business of education (special education more specifically); that those people are then responsible for its propagation; and that “labels allow professionals to communicate with one another about the peculiarities [Molloy’s word] of a child’s personality, behaviour, learning achievements and needs” (p666).

Molloy’s paper is chosen here as it introduces a number of elements relevant to the current study: methodological decision making; functionality of diagnoses as products; and diagnostic dilemmas. These are taken in turn.

The first reason Molloy’s paper is useful is that it makes explicit the connection between world view and research methodology. The medical model of disability is dominated and underlined by the “logical, positivist paradigm of knowledge” and associated objectivist research methods (p 667), a dominance more recently challenged by post-positivist researchers within the social sciences, resulting in subjectivist methods of research and interpretivist analysis, gaining, Molloy would argue,

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<sup>1</sup> Autism is considered to be a disabling condition for the purposes of the Autism Act 2009

a necessary place as legitimate means of inquiry in the field. The methodology of the current study does not align itself implicitly with medical conceptualisations of autism or explicitly align itself with predominating positivist research methodologies. Adopting a social constructionist perspective, it introduces a refreshing methodological approach called for by Molloy et al (2002).

A second reason Molloy et al's (2002) paper is useful is that it calls for readers to consider what or whose needs are being met by diagnosis. Various stakeholders' needs are suggested:

- the need for schools to maintain order and smooth running;
- the need of parents to make sense of their child's behaviour; and
- the needs of professionals to have a shared language for communication to support their practice.

Molloy questions whether the aim of diagnosis and intervention (by professionals) is to 'normalise' and rehabilitate children. This topic of implications of diagnosis is discussed in the later literature review chapter on diagnosis and again in the findings chapter, as something EPs concern themselves with in the course of their work.

A third element of Molloy's (2002) paper is that it raises questions about the categorisation of autism spectrum *disorders* as opposed to an alternative conceptualisation; the dimensionality of neurological *differences*. Kapp et al (2013) explores some assumptions of what is referred to as the neurodiversity movement. They state that,

"neurodiversity proponents tend to adopt a form of the social model of disability, distinguishing between a biological underlying condition or way of being (autism) and disability rooted substantially in inaccessible social and political infrastructures, they essentialize autism as caused by biological factors and celebrate it as part of natural human variation" (p2).

Kapp et al (2013) highlight other ways in which the neurodiversity perspective differs from the assumptions and goals of a medical model. There is less of an interest on causation, cure or

normalisation, a promotion of subjective well-being and adaptive functioning instead of a focus on approximating towards typical functioning and a celebration of strengths, differences and weaknesses as central to identity (p 2).

#### 2.4 What is autism and how does it work?

In spite of contested aetiology, there is perhaps more consensus that autism is understood as a lifelong complex developmental difficulty, appearing usually in the first three years of life, that affects the way a person communicates and relates to others (Bogdashina 2006). The epidemiological work of Wing and Gould (1979) and Wing (1992) made a significant contribution to the clinical understanding of autism, and two aspects in particular are credited to their work. The first is that autism is a spectrum disorder, meaning individuals are affected differently (referred to as heterogeneity of presentation). The second is that autism is understood as presenting as difficulties across the domains of social communication, interaction and imagination, which are often referred to as the Triad of Impairments. The acknowledgement of the heterogeneity of observable manifestations poses some difficult questions both theoretically and diagnostically (Kinderman, 2013). Despite the presenting difficulties in social communication and interaction, some question whether autism is best defined as a social communication disorder, or primarily as a disorder of cognitive processing, which gives rise to the pattern of difficulties with social interaction and communication (Minsheu and Goldstein 1998).

Various theories have been put forward to account for autism. Baron Cohen (2008) summarises his view that there have been 5 major psychological theories of autism (there are others). He evaluates those theories by considering which parts of autism each could explain, and how full an account they provide. He concludes that no theory put forward as yet fully accounts for all the 'difference' or deficit that is considered core in autism. He suggests that psychological theories will need to explain all autistic traits in all individuals on the spectrum, not just some of them (p51). One could question,

however, whether this is a sound premise from which to work, especially if different genes are found to be involved in different presentations. Future research might illuminate whether different psychological conduits are responsible for the expression of differing symptomatology.

## **CHAPTER 3**

### **LITERATURE REVIEW: ATTACHMENT THEORY AND EFFECTS OF EARLY TRAUMA**

#### 3.1. Chapter Outline

This chapter provides an account of the development of Attachment Theory (AT), the implications of insecure patterns of attachment, and the effects of early trauma. The focus on attachment theory and the importance of early relationships is offered because the phenomenology which characterises presentations of autism is similar to the phenomenology associated with early experiences of trauma, abuse neglect and insecure attachments.

#### 3.2 What is Attachment Theory?

AT describes the development of emotional bonds in early infancy, and highlights the importance of the quality of early parent/carer-child relationships for child mental health. The theory asserts that interactions between the child and main (primary) caregiver over the first few years of life provide the building blocks, not only for that relationship, but also for subsequent relationships and more broadly, for the child's overall emotional development. It is the quality of this early relationship that has important implications for the child's neurological, physical, emotional, behavioural, cognitive and social development (Bailham and Brinley Harper 2004).

#### 3.3 Origins of Attachment Theory

John Bowlby, the founder of AT, had a background in medicine and psychology (he was a psychiatrist and a psychoanalyst). In addition he was influenced by the works of Lorenz (1952) and Harlow (1958) in the field of ethology. Bowlby regarded attachment as a biological instinct, which had evolved to ensure survival of the vulnerable young, a position Rogoff may counter from a perspective of cultural diversity (2003). Bowlby argued that attachment behaviour in the young (offspring) is designed to elicit responses from the caregiver that ensure safety, security and protection. AT therefore could be



considered an evolutionary theory in this regard (Prior and Glaser 2006) representing a departure from Bowlby's psychoanalytical roots. This is not the position claimed by other authors. Shaver and Mikulincer (2005) for example, assert that Bowlby (and Ainsworth) combined insights from psychoanalysis, ethology, and developmental psychology', and view AT as a 'contemporary psychodynamic approach' (p22), which now can be verified or backed up by cognitive and neuroscience research. They illustrate in their paper how AT demonstrates agreement with 'five core postulates of psychodynamic theory':

- 1) The role of the unconscious (many components of the attachment behavioural system operate unconsciously);
- 2) The influence of childhood experience in later development (dynamics of the attachment system in adulthood reflect past experiences with relationship partners, especially parents);
- 3) The parallel but sometimes conflicting processes of cognition and affect (attachment strategies can reflect compromises between conflicting tendencies such as hostility to unavailable attachment figures yet intense need for proximity to them);
- 4) Explanations of a person's behaviour in interpersonal / social settings using mental representations of the self and others (a model or theory of transmission that mental representations or internal working models become a person's implicit procedural knowledge making the building blocks of a person's cognitions and behaviours in later interpersonal transactions and relationships); and
- 5) Healthy development reflecting a move from a dependent to an autonomous state (the process of attachment as a developmental journey from social dependence to later 'mature' autonomy) (p25-29).

Gerhardt (2004), despite being a psychoanalyst herself, is less concerned with claiming AT as belonging to the psychoanalytic paradigm over any other. Rather her volume celebrates attempts that have been made to "...integrate recent 'scientific' developments with psychoanalytic thinking...

to understand emotional life in its biological context...and integrate disciplines that have for far too long been kept in rigid compartments" (p5).

Bowlby argued that the child's attachment behaviours become organised by the pattern or style of responding received from the caregiver (Prior and Glaser 2006). This became known as the attachment behavioural system, the aim of which was to bring the vulnerable young into closer proximity to its caregiver, with the expectation that s/he will respond in such a way as to remove them from harm or potential harm.

The theory was expanded by the work of Ainsworth et al (1978) to introduce the,

"notion of the care giver as a secure base from which the infant explores surroundings...and introducing the concept of caregiver sensitivity to infant signals and the role of sensitivity in the development of infant-caregiver attachment patterns" (Wilson 2001, p39).

Caregivers who respond to signs of some form of distress in the infant in a sensitive way, reduce the distress in the infant, who then ceases to display such immediate attachment (proximity seeking) behaviours: they come to 'know' or anticipate that their caregivers will respond in a way that reduces their distress and come to learn to trust that their needs will be met. This allows them to use the caregiver as a 'secure base' from which to explore, safe in the knowledge that help (protection) is close at hand should they call for it. This interaction between attachment behaviours in the offspring and the sensitive and timely responses of the caregiver, with subsequent fading of attachment behaviours, is known as a 'secure' pattern of attachment. Where the attachment behaviours of offspring during times of perceived threat (danger) are not met in this sensitive and attuned way, this leads to different patterns of attachment behaviour – caregiver response interactions, known as insecure attachments.

### 3.4 Assessing Attachment Patterns and Attachment Security

These different patterns of interaction were the focus of much of the work of Ainsworth (Ainsworth et al 1978). Ainsworth's studies using the 'Strange Situation' test were the corner stone of early work that identified 'patterns' of attachment behaviour in infants in situations of separation (threat), and reunion, with caregivers. The work of Ainsworth gave rise to description and categorisation of patterns of interaction as, 'secure' (Type B) and 'insecure' (Type A, avoidant, and Type C, resistant / ambivalent). Ainsworth et al divided these three main categories into eight sub-categories: two sub-categories in Type A, four in Type B and two in Type C. Ainsworth's classification is shown in Figure 1.

Pattern of Attachment	Insecure Attachment	Secure Attachment	Insecure Attachment
<b>Name of Attachment pattern</b>	Avoidant		Resistant
<b>Alpha numeric denominations (sub categories)</b>	A1 and A2	B1 to B4	C1 and C2
<b>Attachment behaviours shown by infants during 'Strange Situation test'</b>	Attention is turned away from attachment related experiences	Attention is flexible and can be directed towards attachment or exploration	Attention is maintained towards attachment related issues
	← -----Suppression	Expression-----→	

Figure 1. Ainsworth et al's attachment classification system of organised attachment patterns, with Prior and Glaser's 'attachment expression continuum'.

Figure 1 represents an overview of the structure of Ainsworth's attachment classification system, which Prior and Glaser (2006) reflect as a continuum of 'suppression of attachment behaviour to expression of attachment behaviour' i.e. Figure 1 would be read from left to right. Thus, 'A1 infants' show consistent avoidance of the mother in 'test' situations, and 'A2 infants' show some tendency to approach the mother. 'B1' and 'B2 infants' are somewhat avoidant (suppression of attachment

behaviour) and 'B3' and 'B4' infants are more readily upset by separations and somewhat like 'resistant infants' on reunion following separation. 'C1 infants' openly display anger and 'C2 infants' are thought to display anger through inappropriate helplessness (expression of attachment behaviour) (p26 and 27). Types A, B and C are described as 'organised patterns' of attachment behaviour.

A further subgroup was introduced to this typology of interactions by Main and Soloman (1986) who re-examined 'Strange Situation' test video recordings to address the observation that the interactions of some infants did not fit into Types A, B or C. Re-examination of recordings found not 'new' attachment behaviours, but rather a range of behaviours thought to reflect a lack of a coherent (organised) strategy for dealing with the stress or threat of separation. They introduced category D, 'disorganised' attachment. This category has been the focus of particular interest and attention in relation to the later development of social and cognitive difficulties and psychopathology (Green and Goldwyn 2002) and 'disorders' of attachment have made their way into the psychiatric arena as diagnosable disorders of childhood and adolescence (Diagnostic and Statistical Manual 4 and 5) (APA, 1994, 2013).

The evolution of classification of attachment behaviours has continued. Crittenden (2000), who earned her PhD under Ainsworth, developed the Dynamic Maturational (DM) Model of attachment. Comparisons with the 'A, B, C and D' models outlined, shows the retention of Types A, B, and C but Type D is replaced with Type A/C. This might appear a minor adjustment as indeed when infants are classified as Type D using the previous model, an attempt is made to identify an underlying 'A, B or C' strategy, giving rise to all manner of possibilities such as 'Disorganised-avoidant' (if A Type strategies are identified) or Disorganised-resistant (if C Type strategies are identified) (Prior and Glaser 2006 p28).

However, further examination of Crittenden's DM model, reveals that it is conceptually far from a minor adjustment of previously existing classification systems. Crittenden (2000) proposes that since the nature of attachment is broadly accepted as a critical developmental variable and that AT and related assessments are now being applied to explore the behaviour of individuals who were not assessed as infants, AT requires theoretical and methodological expansion (p1).

Crittenden offers methodological expansion through an alternative means of evaluating adult-infant interactions i.e. an alternative to the 'Strange Situation' test of Ainsworth. The CARE –Index (Crittenden 2005) method, developed and revised over two decades, is based on three minutes of videotaped play interaction occurring under non-threatening conditions, and is a "dyadic procedure that assesses adult sensitivity in a dyadic context" where adult sensitivity is described as "any pattern of behaviour that pleases the infant and increases the infant's comfort and attentiveness and reduces its distress and disengagement". Crittenden (2005) points out that since the CARE-Index does not elicit infants' self-protective strategies (as there is no threatening condition imposed) it therefore does not directly assess patterns of attachment: rather it assesses dyadic characteristics associated with attachment. As a screening tool, it serves to identify 'risks to relationships' that are not obvious from live observation. Methodological expansion also comes from Crittenden's use of the Adult Attachment Interview to illuminate carers' childhood experiences of care, which she proposes influences their own care giving behaviours towards children.

The DM model offers theoretical expansion through consideration of culture, maturation and developmental context. Crittenden states that she "has come to conceptualise attachment as a theory about protection from danger and the patterns of attachment as strategies for predicting and protecting oneself from danger" (p9). The DM model thus retains Bowlby's 'central organising principle', that perceived danger and the need to prepare and respond to it, shape attachment seeking behaviours. However, the model diverges (or expands in Crittenden's words) here in that

what is perceived as danger varies according to culture, maturation and developmental context. There are, consequently, other associated divergences. Firstly, if culture, maturation and developmental context shape perception of danger, as Rogoff (2003) would agree, then observed attachment behaviour must be understood in its own unique ecological context. Secondly, it follows that reference to or interpretation of 'quality of attachment' poses a particular problem: what is a 'good' quality attachment in one context may not be a 'good' quality attachment in another. Instead, Crittenden (2000) favours the use of terms such as 'pattern of attachment', attachment strategy and also 'self-protective strategy' and views all patterns *adaptive in the context in which they are learned* (p9). So for example, an anxious pattern should not be equated with inadequacies, but rather should acknowledge a child's attempts to cope with the challenges of the world in which they are situated.

"Recognizing the accomplishments and adaptation implied by the non-B patterns and placing them in the ecological context of family, culture and history can help us understand human relationships better and change the negative value placed on the Type A and C patterns" (p10.)

Thirdly, Crittenden suggests that "attachment terminology should carry no implication of evaluation in either the moral or adaptive sense" (p2).

The DM model offers further expansion by reflecting that much research carried out by developmental psychologists has focused on identifying patterns of infant attachment and their temporal extension than on trying to explore the dynamic and interactive effects of maturation on attachment patterns beyond infancy. She suggests a large proportion of study has resulted in static descriptions of observed behaviour but has not explored the developmental processes allied with neurological maturation, which have implications for elaboration at later ages. Rather than wanting to join the 'quest for the holy grail' of pursuing evidence for the stability of attachment across ages, she advocates that attachment theory, and developmental psychologists collaborate with others, particularly those in the field of neuroscience, to explore how attachment elaborates beyond infancy (p6): in other words, through the application of theory, she gives permission for researchers not to

restrict their conceptualisations of attachment, and encourages research practice to look beyond the identification of early infant patterns with the anticipation of linear stability as an exact outcome. Crittenden's DM model (2014, with permission), reflects this dynamic dimension.

**A Dynamic-Maturational Model  
of Patterns of Attachment in Infancy**

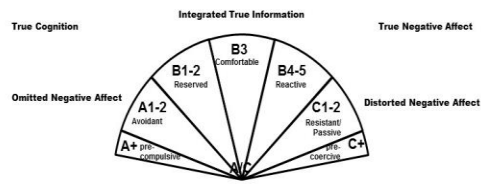


Figure 2a. A dynamic-maturational model of attachment (infant patterns) (Crittenden, 2014, with permission)

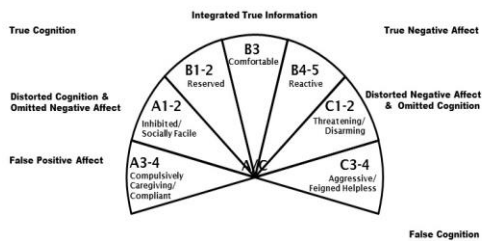


Figure 2b. A dynamic-maturational model of attachment (pre-school patterns) (Crittenden, 2014, with permission)

**A Dynamic-Maturational Model  
of Patterns of Attachment in Adulthood**

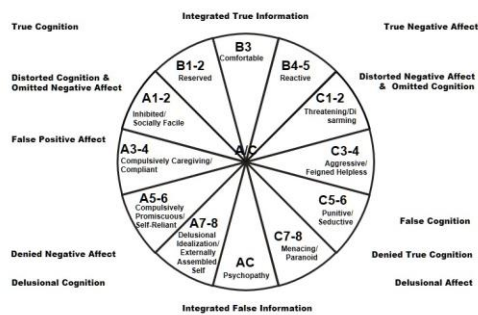


Figure 2c. A dynamic-maturational model of attachment (adult patterns) (Crittenden, 2014, with permission)



Two further dimensions are evident in this model. One is the reduction of Ainsworth's 'trichotomy' to two sorts of information: cognitive and affective. Here the Type A pattern is thought of as a cognitive pattern where behaviour is organised on the basis of previously experienced, predictable, temporal contingencies (i.e. an implicit causal attribution approach). The Type C pattern is one where, feelings organise and motivate behaviour. Type B is conceptualised as a pattern where both cognitive and affective information are balanced in their motivation of behaviour. The other dimension is the degree of integration.

Crittenden (2000) proposes that the DM model 'makes room for maturation', "as more sophisticated cognitive functioning emerges, for example through omitting, distorting and falsifying information during processing, the range or variation of possible attachment strategies increases" (p345). It also 'makes room for context' through its explicit acknowledgement of the widening influences on individuals beyond the exclusive influence of parents, with infants and pre-school aged children adapting with increased specificity to their familial context and school aged children and adolescents adapting with increased variability to meet the more complex demands of their widening social contexts (p351). Crittenden (2008) proposes that it is not only "threats" that change in line with widening social contexts and maturation (for example learning to walk) but also that opportunities for change also arise through maturation (for example increasing communicative capacity through the development of language) (p3).

It is useful to consider here how this DM model of attachment, compares with Bowlby's early views on attachment. He acknowledged this complexity, in his book *Attachment and Loss* (1969). On the one hand he states that,

"Whatever interactional pattern a couple (infant – caregiver couple) has worked out during the first year tends to persist, at least during the next two or three" (p411).

This position would seem at first to contrast with that of the DM model. However, he also makes a suggestion that appears in concordance with Crittenden's dynamic position, even if in a more rudimentary manner than the sophisticated elaboration she now offers,

"...apparently persistent and stable patterns of interaction can be materially changed by events occurring in subsequent years. An accident or chronic illness may make a child more demanding and / or his mother more protective; distraction or depression in the mother will make her less responsive...either event may on occasion so alter behaviour of one or the other that the interactional pattern between them becomes radically changed... (p412).

An additional similarity between Bowlby and Crittenden can be extracted from this quote and from his caution against interpreting the characteristic attachment behaviour of the infant as residing as a property of the infant rather than reflecting the interactional pattern of the infant and its mother (i.e. care giver). Bowlby's and Crittenden's views do differ however when it comes to considering the capacity for change in attachment pattern: where Bowlby viewed that attachment organisation becomes progressively less easily changed as the child grows older, with the pattern increasingly becoming the child's own characteristic response style, it is a fundamental assumption of Crittenden's DM model that such change and adaptation of attachment organisation can take place.

Following in the footsteps of Bowlby and Ainsworth, Crittenden does not describe the roots of her theory but explains that several major theories are integrated into her model (ethology, behavioural learning theory, family systems theory, social ecology, Gestalt theory, Piagetian theory, evolutionary theory, the cognitive neurosciences and others). For example, Bronfenbrenner's theory of social ecology is drawn upon to understand the role of other systems (genetic, behavioural, family, community, political and cultural) in affecting the development of an individual and cognitive neuroscience is drawn upon to understand individual difference in developmental pathways. She also draws upon Piagetian and Vygotskian thinking. The Vygotskian concept of Zone of Proximal Development (ZPD) is drawn upon to explain that, "repeated exposure to unprotected and

uncomforted threats beyond the individual's ZPD results in accumulated risks that leaves the individual with maladaptive strategies" (p4).

Crittenden (2008) refers to a "shift in emphasis" (p11) from Bowlby and Ainsworth's work though in considering her model a "life-span model where early experience influences later development but does not determine it" (p11). Crittenden refers to the two way transaction between the individual and context as generating development pathways (not fixed trajectories), which are open to the possibility of change in the future.

Crittenden (2000) summarises that, to date, three overarching principles have been consolidated through a considerable body of research evidence: the universality of Ainsworth's patterns across a variety of cultures; the association of anxious attachment (Type A) to risk conditions and developmental problems; and the effects of attachment are observed across the entire life span, with evidence of continuity of pattern across both individual lives and generations.

### 3.5 How early attachment relationships contribute to later development

As attachment theory is used to contribute to explanations of later development, an explanation is required to account for how attachment experiences become 'translated' into patterns of interacting, which then exert influence in later stages of development. Crittenden (2008) states that,

"we should keep an open mind that the parent's strategy is not 'transmitted' to the child. Only behaviour is expressed by the parent and only sensory information reaches the child. Children must use that to construct their own strategy" (p120).

There are a number of views about how early patterns exert later influence. Fraley (2002) describes how through repeated interactions, infants and children develop a set of knowledge structures, or internal working models, that represent those interactions. Thus, if caregivers have been generally warm, responsive and consistently available, the child learns that others can be counted on when

needed and consequently s/he is likely to explore the world confidently, initiate warm and sociable interactions with others, knowing that the caregiver is potentially available i.e. has a working model based on secure attachment. Conversely, if caregivers are cold, rejecting, unresponsive, unpredictable or frightening, the child learns that others cannot be counted on for support or comfort, and this structural knowledge is embodied in the internal working model of an insecure attachment pattern (p125). Attempts to regulate behaviour are thus seen as appropriate calls for help (secure working models) or through excessively demanding attention and care or by withdrawing from others in attempts to achieve self-sufficiency (insecure working models). These internal working models become the primary mediators of attachment, which influence the kinds of reactions elicited from others, and the inferences they make about people's intentions. Milan et al (2000) found support for this view in their study: the attachment representations of children placed in care predicted children's perceptions of their relationship with their foster mothers.

Fraley's (2002) meta-analysis of 27 studies regarding stability of attachment pattern concludes in favour of a 'prototype' perspective (where initial working models serve as a relatively enduring prototype for later years) whilst Crittenden's model could be considered reflective of what Fraley refers to as a 'revisionist' prototype (where internal working models are more open to revision through changing experience). Crittenden (2000) suggests that the dominance of research evidence drawing on white, middle class, 'non-risk' and western populations may have contributed to the predominating view of stability of attachment.

Both prototype and revisionist perspectives on the operation of internal working models, could offer explanations of how attachment experience influences individuals later in life. In the prototype perspective, individuals (regardless of attachment Type) use their 'existing' internal working model to initiate and engage future social relationships in a similar fashion. The revisionist perspective might also expect that, all things being equal (i.e. in a situation where individuals are not later exposed to

contradictory experiences that demand revision of existing models), internal working models continue to exert their influence.

Fonagy (1996) expands on the idea of working models. He discusses 'self-reflective functioning' or the metacognitive capacity to reflect on and understand the mental or internal states of the self and others as a further dimension of how attachment exerts its effects. He postulates that self-reflective functioning in children is positively associated with the reflective capacities of the caregiver i.e. that caregivers' high in self-reflective capacity are more likely to promote secure attachment in their children.

Crittenden (2008) uses the term Dispositional Representations (DRs) to replace internal working models. A DR is the mental process that precedes behaviour. The mental processing is referred to as a representation.

"DRs are networks of firing neurones that respond to external information signals (context) and internally generated signals (self). Together these generate a neurological representation of the self, in this context, now. This DR motivates and organises behavioural response. Potential neural networks are formed by frequent reactivation and intense stimulation strengthening particular synapses" (p92).

Crittenden's idea is that 'information' is transformed to a DR about how to act so as to promote safety / protect oneself from danger.

The central role of care-giving relationships is common to all the models of attachment presented in this chapter but Crittenden herself highlighted that a direct transmission model was not appropriate and that 'child factors' (page 23) are also active. The collapse of organised attachment strategy has been explained primarily by inappropriate caregiving but recently, the contribution of child factors such as neurological impairment (Pipp-Siegel et al, 1999) and neonatal behavioural organisation (Spangler et al 1996) have also been suggested. Lakatos et al (2000) claimed that in non-clinical, low-social-risk populations, having a 7-repeat allele predisposes infants to attachment disorganisation,

suggesting that genes may have a contribution to the development of attachment patterns too: “about 15 % of one year old infants in non-clinical, low-risk and up to 80% in high risk (e.g. maltreated) populations show extensive disorganized attachment behaviour (as determined thorough the Strange Situation Test)”. The authors noted that as not all children with disorganised attachment have the allele, it would have been useful if the study could also have looked at maternal sensitivity. In addition, Bernie and Meinz (2008) suggest a threshold approach to understand the origins of attachment disorganisation, with the context in which caregiving behaviour occurs also mitigating the influence of the individual behaviour of carers. Thus, the long established knowledge of attachment theory is open to refinement.

That both an infant’s capability to signal his or her needs to a caregiver and the sensitivity of the caregiver’s responses combine to contribute to the development of attachment patterns, is of particular relevance to the current study. The reasons for this are explained by van IJzendoorn et al (2007),

“Considering the severe impairments in reciprocal social interaction and communication, one wonders whether the parents of children with ASD are able to respond sensitively to their children’s signals and needs in an equally prompt and adequate manner as parents of less socially impaired children. Ainsworth defined sensitivity as the parents’ ability to perceive and interpret their children’s attachment signals accurately and to be able to and willing to respond promptly and adequately to those signals. Children with ASD, however, render their parents’ task of deciphering their signals more difficult because they may not express their emotions in explicit ways. Parents may also have to use less direct verbal responses to avoid interfering abruptly with established routines. To respond adequately to children with ASD may require more careful attunement, more clear-cut nonverbal responses that take the developmental level into account, and more promptness than in the case of typically functioning children. Because ASD has been found to be genetically transmitted, parents of children with ASD may also run the risk of displaying less social interactive abilities than parents of typically developing children” (p598).

Van IJzendoorn et al (2007) speculated, therefore, that the more demanding task of responding sensitively to a socially impaired child, combined with a certain genetic risk for being socially less competent, may lead to lower levels of parental sensitivity. They found that parents of children with autism were equally as sensitive as parents of children without autism but that this sensitivity,

however, did not appear to have the same predicted association with attachment security as found with children without autism.

This finding requires explanation as “one of the basic tenets of attachment theory is the association between parental sensitivity and children’s attachment security” (van IJzendoorn et al 2007, p 604). Van IJzendoorn et al (2007) hypothesise that autism may place biological constraints on the ‘intergenerational transmission’ of attachment, and refer to deficits of joint attention, social mirroring and emotion recognition, as possible factors. The findings of Rutgers et al’s (2004) meta-analysis suggest that attachment and autism are compatible, so it may be the case that the role of parental sensitivity in the development of attachment security is different in children with autism.

The later study of Koren-Karie et al (2009), however, explored the association between maternal sensitivity and attachment security, with some methodological adjustments. They used a larger sample size, took additional measures of maternal sensitivity and took into account the impaired affective signalling of children with autism when coding attachment security. Typically, active greeting, proximity seeking and interaction with mother upon reunion are coded. As children with autism are less likely to show those behaviours or show them in different ways, calming down upon reunion and / or returning to ‘baseline behaviour’ were coded as indications of security (even if they did not actively acknowledge their mother’s return). This study concluded that although children with autism are impaired in their capacity to signal their needs, maternal sensitivity does play the same important role in children for autism as for those without, that is,

“the fundamental hypotheses of the theory, namely, that sensitive caregiving is associated with attachment security, is applicable not only to typically developing children but also to children with ASD” (p647).

In a separate study, the same researchers explored and found an association between maternal insightfulness (‘understanding of the child’s inner world and unique experience’) and resolution

(having come to terms with the painful feelings related to the diagnosis and the loss of the hoped-for, typically developing child) and attachment security (Oppenheim et al 2009).

The relationship between autism and the development of attachment patterns becomes more complex when considering:

- the role of cognitive ability in the development of attachment behaviours; and
- the methodological issues of studies examining the relationship between autism and attachment, including whether the attachment patterns of children with autism can be assessed or inferred using the same parameters as those that are applied to non-autistic children.

Rutgers et al (2004) conducted a meta-analytic review of sixteen studies on attachment in children with autism. They concluded that attachment security is 'compatible with autism'. They report on studies that support the earlier findings of Rogers et al (1993), that of more security of attachment in older children with autism. Van IJzendoorn et al (2007) offer the explanation that children with autism and their parents "may both need more time and effort to develop a predictable and well-matched interaction pattern, which may only become established in pre-school age or may fail to emerge at all" (p 605). Rutgers et al (2004) also concluded that attachment insecurity appears to be associated with severity of autism and the coexistence of 'mental retardation'. They suggest that the construction of an internal working model of attachment relationship in children with autism and mental retardation may develop differently from children without autism.

Rutgers et al (2004) report that research on attachment in children with autism is complicated by the fact that the scoring system for the Strange Situation Test is validated for 'normal' children in the age range of 12-21 months, and that the coding manual for older, pre-school children pre-supposes normal cognitive development. Attachment studies on children with autism have involved children



who are chronologically older, and often mentally older than the upper level of 21 months. Researchers have also been reluctant to adhere to the administration procedures of the Strange Situation Test on ethical grounds (the distress it can induce in children) and so have modified those procedures to shorten the length of separations or reduce the number of them. Van IJzendoorn et al (2007) draw attention to other methodological considerations such as whether extant measures of parental sensitivity and attachment security are adequate and appropriate for use in studies of children with autism.

The papers of Shin et al (1999) and Koren-Karie et al (2009) both refer to the function and potential value of parent-child psychotherapy and sensitivity focused interventions respectively in the arena of supporting parents in their relationships with their children and in promoting secure attachments.

### 3.6 Criticisms of Attachment Theory

The “rigorous scrutiny” of attachment theory Bowlby hoped for (1969 p 411) did follow, but with continuing difficulties. Research findings are difficult to directly compare: they differ in methodological design, population and sample size characteristics, and issues with inter-rater reliability (of Strange Situation test scenarios) to name but a few.

Arguably, one of the most ardent critics has been Burman (2008). From a feminist position, her critique is extensive covering a range of themes: the theory (quoting work that suggests that traditional attachment theory is circular); methodology (such as the retrospective use of Adult Attachment Interviews to identify attachment types in adults when observation is the chosen method for identifying attachment type in infants); the ‘claims’ attachment theory makes (given the dominance of American research, emerging cultural differences in attachment and a myopic focus on mothers as the total environment of the child); the ethics of the research (using children’s distress as

the variable under investigation and manipulation); and the social and political influence that the research has had, and continues to have, particularly with regards to the subjugation of women (p6.)

The latter may be considered to have received Burman's particular consideration. For example, Burman argues that despite modifications of Bowlby's original position,

"...contemporary research on childcare continues to be dominated by a restricted range of questions that betrays a theoretical legacy which positions women as responsible not only for the care of their children, but also for their current and future development...research has been conducted within a paradigm of presumed damage limitation, portraying it (childcare as alternative to full time mothering) as a risk factor....rather than exploring the more useful questions concerning what different organisations of attachment relationships and caring, contexts offer" (p133).

Burman (2008) continues that policy around childcare provision places this responsibility with employers (not the state), reflecting an underlying tie with economic productivity, or else being so extortionate when purchased privately that, mothers (women) continue to be disadvantaged when trying to participate in the world of work.

It is of interest to note that Crittenden's expansion of traditional attachment theory acknowledges, if not fully addresses, several aspects of Burman's (2008) critique (including the ethical issue of inducing 'distress' via her alternative assessment methodology). However, Burman does not refer to or comment upon her contribution to contemporary theory. Despite criticism, attachment theory continues to influence professional practice. For example, it is noteworthy that it is referenced three times (pages 17, 19 and 23) in the good practice guideline on psychological formulation (BPS 2011).

### 3.7 Implications of attachment patterns

The influence of research around attachment has been far reaching including: implications for the foster care placements of children in public care (Milan and Pinderhughes 2000); training of foster carers and adoptive parents (for example, DoCS 2006); examination of the presentation of

attachment behaviours to the classroom (Geddes 2006); and to educational therapeutic intervention (Salmon and Dover 2007). Green and Goldwyn (2002) conclude that the identification of disorganised attachment has greatly increased the potential relevance of attachment theory to general clinical work. Van Ijzendoorn and Bakermans-Kranenburg (1997) found an association between attachment pattern and psychopathology with insecure attachment patterns over represented in clinical samples.

Morton and Brown (1998) explore the relationship between child attachment and maltreatment. They summarise that maltreated children are generally less securely attached to their mothers than non-maltreated children and that maltreatment of children is most likely to be associated with disorganised patterns of attachment (Fonagy, 1996). Fonagy goes on to suggest that individuals who experience severe maltreatment in childhood may be more likely to manifest borderline psychopathology and are at an increased risk of many forms of [Axis-1]<sup>2</sup> disorder (p10). Crittenden (2002) not only agrees with the association of attachment experience and psychopathology but suggests that her model offers a way to interpret, understand and reframe psychopathological behaviour as maladaptive attempts to protect the self. The application of her model goes beyond retrospective accounting and inert descriptions of current behaviour. Part II of her 2008 volume describes and explains how her model can be applied to not only understanding care-giver's interactional behaviours but can also be applied to develop appropriate interventions for families where maltreatment, neglect and abuse has resulted.

### 3.8 Other developmental effects of maltreatment or early trauma

Promoting secure attachment through supporting or improving the attunement, sensitivity, and parenting of care givers has become the focus of many contemporary initiatives; endorsement of breastfeeding by the NHS; baby massage classes; parenting programmes, use of video feedback and

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<sup>2</sup> Axis 1 includes depression, anxiety, bipolar disorder and phobias

psychotherapeutic interventions; a focus on the role of children's centres and health visitors (Sutton Trust, 2014). Conversely, inadequate care giving can lead to child protection proceedings. The developmental effects other than on attachment security, of inadequate care giving, have been explored in research. Gerhardt's (2004) book and Woolgar's (2013) article review some of the more recent research on the neurobiological consequences of maltreatment.

It is not possible to make definitive statements about changes to the brain as a result of different types of abuse at different ages for a number of reasons (Woolgar, 2013). Firstly, individuals have different susceptibilities or resilience to adverse environments (Zeanah et al 2004). Secondly, different parts of the brain are susceptible to specific environmental events at different ages but many of the changes to the brain in response to neglect and abuse are thought to be adaptations to adverse environments, rather than irreparable damage and repair and recovery is possible when care-giving environments are more conducive.

One physiological response to exposure to stress is the release of the 'stress hormone' cortisol, which prepares the body to take urgent action – the 'fight or flight' response. Acute stress experienced over a prolonged period can have a negative impact on the physiology of the brain (Woolgar, 2013). When a critical level of cortisol is reached the HPA axis (the hypothalamic pituitary adrenal) is activated. In maltreated children, the system can be either chronically elevated, and is associated with anxiety and fearfulness preparing the child for further threats, or chronically suppressed, preparing the child for continuing to function as well as they can in an adverse environment. The amygdala (associated with emotion), the hippocampus and the prefrontal cortex (involved in governing higher cognitive functions, such as planning and reasoning, self-regulation, mood and impulse control) are brain areas sensitive to chronic stress. Overstimulation of the amygdala by repeated stress, can mean that children are prone to 'over-perceive' threat and respond in a highly emotional way to what might be considered minor triggers (Brown and Ward,

2013). Damage to the prefrontal cortex caused by chronic stress can impede the development of these skills and has consequences for future learning, behaviour and health (Brown and Ward, 2013). These adaptations to adverse circumstances may become maladaptive when a child moves to a safer environment. Just as brain changes in response to trauma and toxic stress cannot be definitively predicted due to differences genetic susceptibility and resilience, equally, neither can responsiveness to improvements in care-giving circumstances (Woolgar, 2013),

“Some children may recover following fostering or other interventions. Others are more susceptible at the biological level, which may moderate the success of such interventions” (Woolgar, 2013).

“Recall the self-psychological proposal that, because of early trauma, the developing self-object regulatory function is deficient or “damaged.” This development impairment can now be identified as a maturational failure of the right brain affect regulatory system. A large body of clinical observations and psychiatric research strongly suggests that the most significant consequence of early relational trauma is the child’s failure to develop the capacity to self-regulate the intensity and duration of emotional states. The principle that maltreatment in childhood is associated with adverse influences on brain development specifically refers to an impairment of a higher circuit of emotion regulation on the right side of the brain” (Schoore 2009, p199).

### 3.9 The overlapping phenomenology of autism and effects of early attachment experiences.

The overlapping phenomenology between autism and the effects of early attachment experiences is of particular relevance to the current study. Moran (2010) reports that both autism and significant attachment problems might be construed as developmental difficulties and both groups are vulnerable to misdiagnosis (especially when they present with depression and anxiety or when they have good intellectual abilities yet relatively poor relationship skills). For example, Meltzer et al (2003) found that in a sample of looked after children, 8% of the boys aged 11-15, met criteria for a diagnosis within the autism spectrum, much higher than the prevalence rate in the general population.

Presenting difficulties commonly noted in children and young people diagnosed with autism include the following areas: speech; non-verbal communication; social interaction; motor coordination; skills / interests and repetitive activities and resistance to change (Wing, 1981). To summarise, children who have experiences of neglect, abuse or early trauma may experience difficulties with attention

control (knowing what to pay attention to, what to filter out, and appraising 'threat'), emotional regulation (being 'supersensitive' or 'over the top' in reaction, or not reacting at all to events and being prone to 'unusual' anxiety in the face of uncertainty), higher order cognitive functions (planning, reasoning, self-regulation, mood and impulse control), social interactions (building and maintaining peer relationships) and language development, bearing resemblance to the phenomenology of autism (Schwartz et al 2006). Taken from Moran (2010),

"There is an emerging body of research which is clarifying the range of social and communication difficulties seen in children and young people who have experienced early adversity (particularly the work of Professor Sir Michael Rutter; Dr. Helen Minnis; Professor. Jonathan Green; and Professor. David Skuse)".

Developmental outcomes of children who have experienced chronically inadequate care, from an attachment perspective, such as those raised in Romanian Orphanages, have been examined. Rutter et al (1999) studied children from Romanian Orphanages (having suffered physical and social deprivation) adopted by families in the U.K. Arriving in the UK, many of the 165 Romanian babies were assessed as having autistic symptoms (preoccupations with sensations, impaired language development and social responsiveness) but showed 'recovery' with the intervention from their adoptive families, to the extent they were undistinguishable from normally developing children their age (pseudo or quasi autism). Shin et al's (1999) paper reports on a smaller study of Korean children (n=25) who had been given preliminary diagnoses of autism. Presentations leading to those preliminary diagnoses are described in detail and summarised under headings of poor social interaction, speech and language difficulties, stereotypic self-stimulative behaviour, self-mutilating behaviours, nonspecific negative or aggressive behaviour, dysregulated activity levels and obsessive rigidity. The paper reports that the children did not have histories of 'severe abuse' or chaotic family environments but the information obtained during more extensive interviews with parents highlighted a range of factors (maternal mental health, separation, consistency of caregiving, and emotional availability of the caregivers) that could constitute compromises to the development of attachment relationships: maternal postnatal depression with histories of depression prior to

childbirth (nine mothers); maternal experiences of childhood separation or attachment difficulties with their own parents, bereavement, a history of heavy alcohol intake (one mother); families characterised by infant-parent separation after birth until 18 months or 3 years with infants residing with grandparents (four families), maternal reports of difficulties bonding emotionally with their babies; the presence of siblings with particular caregiving demands (six families reporting chronic physical or psychiatric illnesses necessitating a large proportion of available parental attention including periods of parents being away from home during hospitalisation when care was provided by several different caregivers), issues around maternal employment necessitating frequent changes of caregiver (six families), marked financial stress (two families), and finally maternal chronic physical illness requiring hospitalisation (two mothers). In addition to those histories, observations of infants during the course of their evaluation indicated changes in behaviour towards, and play, with staff. Mothers' on the other hand, failed to join in play and engaged in parallel play or 'taught the mechanics of play in an educative way', appeared insensitive to their child's cues and were 'scanty' in their emotional expression. Social relatedness and other 'symptoms' (attention control, cognitive development, hyperactivity, emotional blunting, lability, aggression and language) improved following intervention to enhance parent- child relations.

Pear et al (2005) studied theory of mind and emotion understanding capabilities of maltreated young children in care, and found them to compare less favourably to non-maltreated children living with their biological families.

Sadiq et al (2012) discuss that whilst on the one hand, classification systems state that reactive attachment disorder (RAD) is thought to be distinguishable from autism spectrum disorders, on the other there has been very little research to guide clinicians towards this differentiation; evidence based assessment protocols are lacking. In terms of differences, they report that autism frequently occurs in adequate caregiving environments (RAD does not) and the repetitive and stereotyped

behaviours seen in autism are not expected in RAD. With respect to similarity of presentation, they report that children with a diagnosis of RAD appear to show difficulties in social understanding in a number of areas often associated with autism: interpretation of social cues, understanding social hierarchies, a lack of subtlety in discriminating the different expectations of interaction in varying contexts, and language problems. Their comparisons of pragmatic language functioning found that children with diagnoses of RAD demonstrated significant problems in their use of context, rapport and social relationships with a degree of severity equivalent to children in an autism comparison group. They suggest that RAD and autism may differ in terms of an overall profile of symptomatology, and that the overlap is confusing for clinicians, especially where details of early development are not available. Equally, they acknowledge the possibility that some children may meet criteria for both RAD and autism. They conclude that “it will be essential therefore that differential diagnosis is made using multidisciplinary assessment, contextual information (including from school) and observational information in addition to caregiver report” (p275).

### 3.10 The coexistence of autism and the enduring effects of early attachment experiences

The co-existence of autism with other difficulties such as anxiety and depression is documented (Galanopoulos et al 2014). Simonoff et al (2008) report that psychiatric disorders are common and frequently multiple in children with autism spectrum disorders (for example, Attention Deficit Hyperactivity Disorder, Anxiety Disorders and Oppositional Defiance Disorder). They suggest that the infrequent identification of comorbid psychiatric disorders in autism may be, in part, because psychiatric symptoms are attributed to intellectual disability instead. They note too, as specific challenges to comorbid psychiatric assessment in ASD, the wide range of cognitive ability and communication skills, which make personal interviewing difficult and may give rise to uncertainties in care givers’ accounts. Despite these diagnostic difficulties, they posit that “delineating psychiatric comorbidity may identify targets for specific intervention that could reduce overall impairment and improve quality of life” (p 922).



The preceding section outlined that the phenomenology of autism and attachment difficulties can appear similar. It is also entirely possible, that autism and attachment difficulties can co-exist. Several strands are drawn together here. Firstly, psychiatric disorders are common and frequently multiple in children with autism spectrum disorders. Secondly, an association between insecure attachment patterns / early attachment experiences with later psychopathology is reported (van IJzendoorn and Bakermans-Kranenburg 1997 and Crittenden 2002). Thirdly, delineating psychiatric comorbidity can differentially inform intervention', and thereby, enhance an individual's quality of life (Simonoff 2008). It is, therefore, reasonable to suggest that identifying the co-existence of autism and the effects of attachment experiences, whilst challenging, is meaningful.

The reporting of clinical casework might offer avenues for further research. Clinical experience includes examples of children where autism has been diagnosed in their early years (before the start of formal education). In later years, educationalists have found the children's behaviour increasingly challenging to manage, sometimes to the extent that moving to specialist educational provision is suggested as appropriate. In those cases, the challenge seems to have arisen from issues of emotional regulation and behaviours that are not readily cross referenced with, and accounted for by the criteria described in diagnostic classification systems for autism. Staff with significant experience of supporting children with autism, have reported feeling at a loss to explain the apparent volatility and unpredictable nature of children's behaviour, children who are verbally and cognitively able. Staff have felt unable to apply their extensive knowledge of the heterogeneity of autism presentation, and their amassed repertoire of strategies to effect positive change in reducing the displays of challenging behaviour. Clinical casework examples such as these, may offer opportunities to explore the possible coexistence of autism and effects of attachment experiences.

Drawing the chapters on autism and attachment to a close, it is worthwhile highlighting my comparative conceptualisations because the current study explores the conceptualisations of fellow professionals. I do this in Table 1.

Table 1. My comparative conceptualisation of autism and attachment

Area	Autism	Attachment
Origin	A neurodevelopmental disorder with organic (genetic) and other (as yet unidentified) 'trigger' / environmental element.	Early care giving experiences – experiences of social relationships are the cause
Mechanism	'Organic substrate' determines atypical neurological development resulting in atypical processing in social communication, interpersonal relationships and behaviour	Early care giving experiences lay down (otherwise typical) neurological pathways which shape the possibilities for engagement in relationships and emotional regulation
Identification	Multi-disciplinary assessment advocated in NICE Guidelines in the UK which includes the use of specialist tools (ADOS, ADi)	Local variation. Often single agency assessment (predominantly CAMHS) where early adverse care giving is known and social and emotional problems are evident. Less likely to be considered in the absence of extreme early experience
Phenotype	Heterogeneity of presentation	Heterogeneity – disturbances may be manifest as a variety of behavioural phenotypes with a continuum of 'severity'
Terminology	Diagnostic criteria and classifications described in IDC 10 and DSM 5	Diagnostic criteria for RAD and DESD given in DSM 5
Construction at diagnosis	Biological origin, no blame / responsibility assigned	Social in origin, inadequate /inconsistent/ neglectful caregiving at root.
Intervention	Aimed at providing consistency and predictability of 'things' and routines (which is often best achieved through the knowledge and familiarity of routine to minimise anxiety) usually both home and school, combined with teaching of social and coping skills, usually provided by local authority ('education') staff	Some degree of overlap. Sometimes individual therapy or family therapy delivered by specialists. Support for school settings provided by local authority ('education') staff
Prognosis	A life- long condition. Social skills and coping mechanisms can be taught to avoid triggers / manage difficult situations	Enduring effects in domains of emotional social and occupational functioning when early experiences have been adverse in the extreme but opportunities for therapeutic relationships with enlightened others, especially when brain plastic mean that more adaptive ways of interrelating can be established for those from less extreme circumstances .
Power	High valence lobbying, nationally recognised protection of rights through legislation, assigned and commissioned services	Low valence, no legislative protection, fewer assigned services, no commissioned services

## CHAPTER 4

### LITERATURE REVIEW: DIAGNOSIS, FORMULATION AND PROBLEM ANALYSIS PRACTICE OF EDUCATIONAL PSYCHOLOGISTS

#### 4.1 Chapter Introduction

This chapter will address the diagnostic practices of autism and attachment difficulties here in the UK, informing the reader about the diagnostic criteria in use (subsection 4.2) and the tensions associated with psychiatric diagnosis (subsection 4.3). Attention then turns to differential diagnosis (subsection 4.4) and more specifically focusses on the differential diagnosis of autism from attachment difficulties in light of the suggested overlapping phenomenology (subsection 4.4.1 and 4.4.2). The problem analysis practice of Educational Psychologists as professionals often presented with unclear problems such as overlapping phenomenology by service users is introduced (subsection 4.5) before the chapter is drawn to a close (subsection 4.6).

#### 4.2 Diagnostic Criteria

There are two publications that contain diagnostic criteria for autism and attachment. The Diagnostic and Statistical Manual (or DSM as commonly referred to) for psychiatric disorders is published by the American Psychiatric Association. 'ICD' is the International Classification of Diseases published by the World Health Organisation. Both publications are subject to periodic review. DSM 4 has been updated and the latest version, DSM 5, has been available in the UK since May 2013. ICD 10 was scheduled to be updated in May 2015, this having been put back from 2014 (Roberts et al 2015) but the revision is now more likely to be finalised between 2017 and 2018 (<http://www.who.int/classifications/icd/revision/en/>)

Taking autism spectrum conditions first, although Kanner's and Asperger's work is located historically in the 1940s, Infantile Autism was not introduced into DSM until in 1980. This became renamed as Autistic Disorder in 1987 and Asperger's was not included until 1994. Post World War II

recovery and translation of works into English both probably contributed to the time frame for early works to become incorporated into widely available documents. It is useful at this juncture to indicate how the diagnostic classifications and terminology in DSM and ICD compare. A comparison is provided in the Table 2. Under these classifications, various criteria are outlined which need to be met for a diagnosis to be given. In the case of ‘autism’, it is a requirement that a certain constellation of symptoms are present, and present in sufficient degree that they represent a ‘clinically significant impairment’, which is not better accounted for by other explanations.

Table 2. A comparison of diagnostic classifications for Autism spectrum disorders

<b>DSM 5 (1 category)</b>	<b>DSM 4 (5 categories)</b>	<b>ICD 10 (8 categories)</b>
Autism  Level 3 (severe) ‘requiring very substantial support’  Level 2 (moderate) ‘requiring substantial support’  Level 1 (mild) ‘requiring support’	299.00 Autistic Disorder	F84.0 Childhood Autism
	298.80 Rett’s Disorder	F84.2 Rett’s Syndrome* <sup>3</sup>
	299.10 Childhood Disintegrative Disorder	F84.3 Childhood Disintegrative Disorder*
	299.80 Asperger’s Disorder	F84.5 Asperger’s Syndrome
	299.80 Pervasive Developmental Disorder not otherwise specified (PDD-NOS) (including Atypical Autism)	F84.1 Atypical Autism
		F84.8 Other Pervasive developmental disorders  F84.9 Pervasive developmental disorders, unspecified
		F84.4 Overactive disorder associated with mental retardation and stereotyped movements*

High Functioning Autism is not a diagnostic category in any of these classifications, but appears to refer to Autistic Disorder / Childhood Autism with an IQ of >70.

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<sup>3</sup> \*Considered rare and some debate as to whether they are part of the Autism Spectrum according to ICD 10

It could be argued that there were no apparent substantial differences between DSM 4 and ICD 10, as the diagnostic classifications were broadly comparable, albeit expressed by different terminology. The proposed and accepted changes to DSM 4 made the existing differences between DSM, and ICD 10, bigger. A summary of changes to DSM 5 criteria for autism is provided in Box 1.

- The three previous domains of criteria (social interaction, social communication and restricted and repetitive behaviours and interests aligned with the Triad of Impairments) became two: social communication/ interaction and fixated interests and repetitive behaviours, the latter now including sensory sensitivities.
- Asperger's has been removed as a classification
- DSM has reduced from 5 diagnostic categories to 1: 'Autism Spectrum Disorder', whereas ICD (11) intends to hold on to existing categories and perhaps include a new, 'social reciprocity disorder' (extending the current classification system to 9)
- 'Severity' of presentation is assigned a numerical value.

Box 1. A summary of changes to the classification of autism in DSM 5.

The APA website (2016) explains the changes between DSM 4 and 5 for Autism,

"Autism spectrum disorder is a new DSM-5 name that reflects a scientific consensus<sup>4</sup> that four previously separate disorders are actually a single condition with different levels of symptom severity in two core domains. ASD now encompasses the previous DSM-IV autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASD is characterized by 1) deficits in social communication and social interaction and 2) restricted repetitive behaviors, interests, and activities (RRBs). Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present".

According to the National Autistic Society (NAS) website (2013) emphasis in diagnosis using DSM 5 will change from naming the condition, to identifying the needs someone has and how these affect their life (i.e. their support requirements). The changes to the classification of autism are addressed under point 6 of Frances' '10 worst changes [to DSM] to be ignored' (2012, see Box 3, page 58). The removal of the Asperger's Disorder classification from DSM 5, led to much on line discussion in the UK about the implications for those who already had a diagnosis, tying in to the philosophical

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<sup>4</sup> 'Scientific consensus' is one perspective that is challenged elsewhere in this thesis, including the concerns about DSM 5 within this chapter but also in literature review chapter 2 about autism.

contemplations about the nature of ‘what exists’, introduced by Molloy’s (2002) paper in chapter 2.

Those philosophical contemplations include:

- ‘Does the removal of a classification, such as Asperger’s mean that ‘it’ no longer exists?’
- ‘How does our use of language / labels in describing common patterns within presentation both construct and influence diagnostic practice?’
- ‘How can diagnostic practice be altered in this way without an underpinning research/ evidence base that indicates that a classification is better described (and constructed) in new ways?’

A number of interconnected topics arise from these questions which warrant closer attention. These are picked up again, in section 4.2, after first introducing parallel detail about the diagnostic criteria for attachment.

Chapter 3 noted that attachment patterns are not presented in diagnostic classification manuals but attachment disorders are<sup>5</sup>.

“Attachment disorders are the psychological result of significant social neglect, that is, the absence of adequate social and emotional caregiving during childhood, disrupting the normative bond between children and their care givers” (Lubit, 2015).

Diagnostic criteria for attachment disorders were first introduced into DSM 3 under Reactive Attachment Disorder (a childhood diagnosis). Zeanah et al (1998) point out that the criteria have changed substantially over time. In DSM 4, two types of Reactive Attachment Disorder were delineated; Inhibited (emotionally withdrawn) and Disinhibited (indiscriminately sociable). In DSM-5, these subtypes became defined as distinct disorders: reactive attachment disorder (RAD) and disinhibited social engagement disorder (DSED). The APA (2013) explains the changes,

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<sup>5</sup> There is some debate about whether attachment disorders are best seen as extremes of attachment presentation or as separate and distinct from attachment patterns (e.g. Minnis et al 2006).

“Both of these disorders are the result of social neglect or other situations that limit a young child’s opportunity to form selective attachments. Although sharing this etiological pathway, the two disorders differ in important ways. Because of dampened positive affect, reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults. In contrast, disinhibited social engagement disorder more closely resembles ADHD; it may occur in children who do not necessarily lack attachments and may have established or even secure attachments. The two disorders differ in other important ways, including correlates, course, and response to intervention, and for these reasons are considered separate disorders” (APA, 2013).

ICD 10 similarly defines two classifications, Reactive Disorder of Childhood and Disinhibited Attachment Disorder of Childhood, which are summarised in Box 2.

- Markedly disturbed and developmentally inappropriate social relatedness in most contexts
- The disturbance is not accounted for solely by developmental delay and does not meet the criteria for PDD
- Has an onset before 5 years
- There is a history of significant neglect
- There is a lack of identifiable preferred attachment figure
  
- abuse (psychological or physical) in addition to neglect
- associated emotional disturbance
- poor social interaction with peers, aggression towards self and others, misery and growth failure (inhibited only) and
- evidence for capacity for social reciprocity and responsiveness as shown by elements of normal social relatedness in interactions with appropriately responsive, non-deviant adults (disinhibited only).

#### Box 2. ICD 10 criteria for Attachment Disorders

Differently to autism, certain environmental conditions (history of care) are needed, in addition to observable behaviour, for the diagnostic criteria to be met (five of the nine criteria listed in Box 2 relate to history of care). Similarly to the diagnosis of autism, it is a requirement to check that criteria are not met for other conditions. The stated requirement to ‘rule out PDD’ before proceeding to a diagnosis of attachment disorder offers a hint of agreement with the presentation in the previous chapter that there are similarities in their phenomenology. The criteria of



‘developmentally inappropriate social relatedness, poor social interaction with peers, aggression towards self and others, and emotional disturbance’ explicates this agreement more so.

The criteria for attachment disorders have been criticised along a number of lines: “a focus on social abnormalities rather than maladaptive attachment behaviours; the inclusion of pathogenic parental care; the requirement of cross –situational consistency in symptom manifestation, and the representation of a maltreatment ‘syndrome’ rather than attachment disorder” (Wilson 2001, p44). Minnis et al (2006) point out that disorganised (type D patterns) are thought to occur in around 15% of mother-infant dyads whilst RAD is thought to be rare and pervasive across contexts and RAD behaviours can co-exist with apparently secure attachment behaviour, so insecure attachment is neither necessary nor sufficient for RAD, leading to the “biggest problem with diagnosis [being] the presumption that attachment is a core aetiological factor” (p338). Minnis et al (2009) also reported on these concerns and summarise that studies of institutionalised and ‘ex-institutionalised’ children have demonstrated that secure attachment patterns can co-exist with ‘RAD-like’ behaviour. Therefore, they posit that RAD may represent “a more pervasive and diffuse disruption of social development than the relatively discrete and dyadic – specific alterations in goal directed behaviours [proximity, security, safety and regulation of affective states] conceptualised in classic attachment theory” (p939). Follan et al (2010) suggest that RAD arises from a complex interplay of genetic and environmental triggers.

#### 4.3 Tensions associated with psychiatric diagnosis

This section picks up a number of topics for closer attention that arose (in subsection 4.1) when considering the implications of the changes to the diagnostic criteria for autism. One topic is the range of concerns that have been expressed about the DSM 5. Another was the issue of apparent objectivity of psychiatric diagnosis. These will be taken in turn next.

Concerns about the entire publication of DSM 5 have been extensive, if not unparalleled: across continents; across professional groups and even from within the professional body responsible for producing the publication. In the U.K, the then proposed and now agreed version of DSM 5 drew a significant amount of attention, summarised in Box 3.

The association of drug companies with DSM-5 revisions led to accusations of undue corporate influence within APA and of clear corruption. According to Cosgrove (2009) a significant proportion (69%) of DSM-5 taskforce members had financial ties to the pharmaceutical industry.

Allen Frances (part of the DSM 4 team) stated that the production of DSM 5 had been too closed, lacked independent reviews and that essential pre-publication field-testing steps (of impact of criteria in real life) had been cancelled. Concern also included that 'dangerously broadening' the diagnostic width of the categories of mental illness, would lead to an increase in 'false positives', whilst in relation to ASD, concern was that new criteria would lead to far fewer diagnoses than previously (2012).

Concern about the subsequent risks of over prescription of psychotropic drugs for school aged children was presented as a safeguarding issue (Traxton, 2013).

The reliability of DSM 5 was less than DSM 4 (Kinderman, 2013).

### Box 3. Summary of contentious issues surrounding DSM 5

In relation to 'severe ethical concerns about lack of scientific rigour and potential safeguarding issues', a 1,000 strong professionals' petition (including 15 professors, and over 200 'doctors') was submitted to NICE (National Institute for Clinical Excellence) asking them to consider the issues raised, aiming for a restriction on the use of DSM 5 in the UK. In publishing a response to DSM 5, the DoH (Department of Health) wrote,

"Our knowledge about the human mind is dwarfed by our understanding of the rest of the body. We have tools that can confirm a diagnosis of a sprained ankle or a damaged lung with pinpoint accuracy. No such tools currently exist to accurately diagnose a "damaged" mind. It could be that our current models of human psychology could be as flawed as the "four humours" model of medieval medicine. Criticisms of the DSM-5, such as the issue of medicalising mental wellbeing, are legitimate areas of debate. This debate is to be welcomed if doctors are to appreciate the scale of the challenges of better diagnosing, treating and caring for people with mental health conditions. These challenges are likely to persist in the decades to come. Rather than seeing the DSM-5 as the "Psychiatric Bible", it may be better to think of it as a rudimentary travel guide to a land we have barely begun to explore" (DoH 2013).

The British Psychological Society (June 2012) submitted a response to the APA, which outlined a raft of reservations:

- categories were based on committee decision and public response, not patterns arising out of the identification of underlying mental phenomenon;
- judgements about pathology are grounded in subjective and cultural norms (rather than signs);
- not taking into account the dimensional nature of symptoms across the general population;
- not taking into account the increasing evidence of social and relational factors known as primary risks for mental distress; and
- catch all categories ('NOS' / 'atypical') are problematic, suggesting that research look at the general population before presuming pathology.

Such significant and extensive concerns about the validity and reliability of one of the diagnostic manuals, cast a shadow over the integrity of the business of diagnosis.

Moving on to address the second topic, the apparent objectivity of diagnosis, the practice of diagnosis itself can be considered contentious. To the lay person, diagnosis usually has connotations of being informative; identifying a phenomenon for the purpose of being able to respond appropriately, or being able to take action. In medical terminology, responding appropriately would usually infer notions of treatment. In education terms, responding appropriately invokes ideas for management/ intervention, and in social care terms often has connotations of support. Johnstone (2014), a clinical psychologist, writes extensively on the subject of diagnosis. In particular she writes about the problems posed by psychiatric diagnosis aligning itself with medical diagnosis, about psychological formulation and hypothesis generation (as alternatives to psychiatric diagnosis) and about both the perceived benefits and disadvantages of psychiatric diagnosis. As these are all themes pertinent to the current study, they will be used to structure the discussion in the following sections.

The current predominating model within psychiatric diagnosis positions mental distress (and autism is included in the manual or encyclopaedia of mental distress) as an illness which needs a medical

diagnosis. Medical diagnoses are based on signs and symptoms. Within the medical model, the diagnosis follows an algorithm: ascertain symptoms, identify signs (biomarkers), and diagnose illness (with a scientifically sound and accurate label), and then proceed to hospital admission/ treatment / medication (which is evidence based). This pure medical or biomedical model is not generally supported by psychiatrists in the UK and a popular version of this model is the biopsychosocial model (vulnerability / stress model); a mixture of biological predisposing vulnerability factors, which can be triggered by stresses (poverty, bereavement etc.). Johnstone (2014) suggests that whilst the biopsychosocial model is preferable to a narrow biomedical one, it nonetheless has its faults.

Medical diagnoses should:

- help decide on correct treatment;
- predict the outcome (prognosis);
- provide a basis for research;
- suggest what the aetiology is;
- enable professionals to communicate with each other;
- provide information (and relief) for patients and carers; and
- help people access services / benefits etc. (p22)

However, because there is not a reliable classification system in psychiatry, and in most cases there are no signs (biomarkers) to prove there is a biological disease process at play, psychiatric diagnosis falls short on a number of these assumed purposes, and raises the fundamental question, in Johnstone's view (2014) as to whether psychiatry should really be considered a branch of medicine at all. In the absence of biomarkers, the diagnostic approach is reliant on observation of or reports of symptoms, and therefore, drawing the line between 'normal' and 'abnormal' is problematic (Johnstone, 2014). For Johnstone (2014), the idea that psychiatric diagnoses give explanations is a seductive one, as they are in fact circular and do not explain anything, and are best seen as social judgements, not medical ones (p32). Cosgrove and Reiger (2009) also write about the problems of validity in psychiatric diagnosis,

"That is, to the extent that *DSM* is constructed as a reliable diagnostic taxonomy that emphasizes relatively short-term, acontextual symptoms that tend to be insensitive to characterological variability in expression, it encourages overuse of diagnostic checklists. Among other things, diagnostic checklists provide the basis for outcome measures in clinical trials conducted by industry-funded

researchers [who] then maintain that the “evidence-based research” speaks for itself, that the disorder has been validated... Diagnostic checklists thus become established as good science...Therefore, although checklists can facilitate diagnostic reliability, too often they become self-serving industry tools and lead to inflated statistics about how many people are “suffering” from a disorder. They also make it more difficult for researchers and clinicians to consider context and individual variability. The end result [is] of a diagnostic manual with acceptable reliability but limited validity. The relative neglect of psychodynamically informed narrative descriptions in *DSM* has led to it being of limited use in serving as a guide for psychodynamically informed treatment approaches whose benefit-to-risk ratio increases over time. Clearly, if the APA is to continue to be entrusted with the task of creating unbiased diagnostic systems and treatment guidelines, it must refocus attention on the issue of diagnostic validity” (p1).

Kinderman (2013) spoke of responsible clinical practice relating to diagnosis. In his view, reliable diagnosis requires training of diagnosticians, processes of inter-rater agreement, clinical interviews, multiple perspectives and assessment over time.

Johnstone highlights the impact of these social judgements that are psychiatric diagnoses,

“professionals should always remember that giving someone a psychiatric diagnosis is an immensely powerful act which has profound implications for their identity, relationships, place in the community, employment, health and future” (p57).

The advantages and disadvantages she highlights are summarised here as they are issues raised in the talk of EPs, discussed in the findings chapter of this thesis. As disadvantages, she notes that:

- Individuals can feel helpless, powerless, and stuck – taking on the ill / sick role (where contributing maladaptive relationships remain unaddressed);
- stigma (a person’s internal sense of shame, inadequacy and difference) and discrimination (unfair and oppressive barriers to full participation in society) (p56) are common’;
- issues of blame, guilt and responsibility are complex; and
- overall, diagnosis has profound impacts on identity, relationships, and an individual’s whole life.

Positive outcomes or reactions to diagnosis are summarised as:

- relief at knowing ‘what is wrong’;
- enhanced self-understanding and understanding of others;
- having distress recognised;
- being freed from guilt and blame; and
- routes to and access to appropriate information and support services.

In specific relation to the last point in this summary list, a question of utility often arises. In the subjective arena of clinical practice, it is acknowledged that diagnoses are sometimes 'awarded' (all other things considered) on the basis of the answer to the question, 'what practical utility would it afford?' In other words, what resources / services might become available to the person if a diagnosis were given, what might be 'withheld' if it weren't? This very much echoes Malloy et al's (2002) concern mentioned previously about society's response to individuals. Various letters were exchanged in *The Psychologist* (December 2014 to May 2015, Jordan, Alladin and Collins) exemplifying the heated debate around the utility of diagnosis.

Molloy (2002) writes that the medical model approach to classifying developmental disorders in particular, is largely counter-productive: 1) children once 'labelled' tend to be defined by their diagnosis losing their individuality and limiting others' expectations of them, the diagnostic label filtering their characteristics so they are viewed as symptoms of their disability rather than as an expressions of their unique personality , 2) the problems become located within the individual , and the problem is seen as residing within the individual not within the expectations of social contexts that they inhabit / exist in. EPNET (an online forum for discussion amongst Educational Psychologists) postings similarly reflect professional disquiet in practices pertaining to labelling and diagnosis. These concerns surface in EPs' accounts of their problem analysis process and are discussed in the findings chapter. Occupying somewhat of a middle ground is Bishop (1989) who writes,

"There has been much criticism of the 'medical model' approach to developmental disorders as unhelpful at best and counterproductive at worst...However real though these drawbacks are; we abandon diagnostic labels at our peril. Without them we have no means of generalising from past experience to plan treatment or to give a prognosis...Diagnostic categories also provide a structure for gathering information in a clinical setting and are vital if we want to conduct research into likely causes and appropriate means of treating various disorders. This is not to say that we should adopt an uncritical approach to the labels currently in use. We need to regard them as a useful way of summarising information, but be alert to the possibility of improvement...we may find it necessary to move away from a strictly categorical syndrome-based approach. Finally, one should be aware of reifying labels and treating them as explanatory concepts" (p108).

#### 4.4 Differential diagnosis

Ongoing concern about the validity of existing classification systems and the practice of psychiatric diagnosis, theoretical differences amongst clinicians, and methodological research difficulties all contribute to the complexities of diagnosis. For example, diagnosing autism in females (Gould et al 2011) and very young (Vig et al 1999) or older individuals is complicated by diagnostic criteria developed largely on clinical material about males and children respectively. Attachment Disorders are classified as disorders of childhood, and are not 'applicable' to older 'young people' or adults, so are not conceptualised as lifelong 'conditions', despite the potential lifespan effects or early attachment experiences.

Diagnosis of autism is currently made only through clinical interpretation of phenomenology, that is, the phenotype of a possible underlying genotype. If, as some predict (Kinderman, 2013), the genetic puzzle is unlikely to be resolved in the near future, it is likely that diagnosis will continue to be made on phenomenology alone. Wing (1981) wrote about the challenges of this position over 30 years ago,

"As with any condition identifiable only from a pattern of abnormal behaviour, each element of which can occur in varying degrees of severity, it is possible to find people on the borderlines of Asperger syndrome in whom diagnosis is particularly difficult. Whereas the typical case can be recognised with ease by those with experience in the field, in practice it is found that the syndrome shades into eccentric normality, and into certain other clinical pictures. Until more is known of the underlying pathology, it must be accepted that no precise cut-off points can be defined. The diagnosis has to be based on the full developmental history and presenting clinical picture and not on the presence or absence of any individual item" (p120).

Frith (2008) notes that behavioural features are particularly problematic; they change with age, and ability and there are no unique behaviours that unequivocally identify autism (p107).

Diagnostic decision making must also satisfy other requirements. In the cases of autism and attachment disorders, diagnosticians must also satisfy themselves that the profile of difficulties

illuminated through the assessment and evidence gathering process, represents a 'clinically significant impairment' and is not better accounted for by other factors. Combined, this means that within a process which adopts ostensibly objective criteria, there is significant room, and place, for subjective interpretation. Malloy (2002) reminds us the subjective interpretation of criteria amongst clinicians means that there are 'shades of grey' in deciding between eccentric normality on the one hand and certain other clinical pictures on the other. Of particular relevance for the current study therefore, is the literature base on differential diagnosis; the practice of distinguishing autism from other conditions.

#### 4.4.1 Literature guiding differential diagnosis

This section addresses the ways in which the challenging task of differential decision making is supported by the literature.

Research has been specifically designed to explore the apparent overlap with other diagnoses, with the intention of understanding more clearly the presenting differences between autism and:

- developmental delay in the early years (Dawson et al 2002), (Rogers et al 2003) (Trillingsgaard et al 2005), (Ventola et al 2007) and (Mitchell et al 2011);
- language disorders (Bishop 1989), (Mildenberger et al 2001) (Noterdaema et al 2000), (Mawhood et al 2000), (McArthur et al 1996), (Mouridsen et al 2009) and (Reisinger et al 2011),
- developmental delay with delayed language (Ventola et al 2007);
- severe learning disabilities (Hadwin et al 1998), (Kraijer, D. and de Bildt, 2005), (Vig et al 1999), (Matson et al, 1998);
- deaf blindness with profound intellectual disability (Hoevenaars-van den Boom et al 2009); and
- ADHD (Buhler et al, 2011).



The Appendices to the NICE guidelines (Good practice guidelines for England) is one source of information about a range of other conditions to assist clinicians with differential decision making between diagnoses with similar features (Appendix K for the NICE Guidelines, 2011). Included are:

- Neurodevelopmental disorders (specific language impairment, intellectual disability, DCD);
- Neuropsychiatric disorders (ADHD, mood disorder, anxiety disorder, attachment disorders, ODD, Conduct disorder, OCD);
- Conditions in which there is developmental regression (Rett's syndrome, epileptic encephalopathy);
- 'Other' conditions (severe visual and hearing impairments and selective mutism); and
- Attachment disorders.

The differential diagnostic advice pertaining to autism and attachment disorders in the Appendix (p243-244) is represented in Table 3.

Theme	Autism	Attachment
Social overtures that appear inappropriate / indiscriminate / uninhibited	Behaviour may lack normal boundaries but this is less likely to be in order to gain social attention	More likely to be to gain social attention
Eye contact aberrant	As it is poorly regulated	As it is emotionally avoidant
Attachment behaviours	Can show behaviour suggestive of appropriate separation anxiety but greeting and farewell behaviour may have an unusual quality	
Play when given access to developmentally appropriate toys	Can lack imagination	Can show relatively normal imaginative play

Table 3. Advice to health care professionals on the differential diagnosis of autism and attachment disorders extracted from the Appendix K of NICE Guideline (2011)

Lura Tibbits-Kleber et al (1985) state that determining autism from an attachment disorder would include consideration that children with autism are likely to be of normal size and weight and rapid physical improvement would be seen after hospitalisation for children with RAD (failure to thrive), whilst children with autism are unlikely to improve their presentation upon being removed from home. Mukaddes et al (2000) similarly found that the presence of 'pathological care' (as an aetiological factor) and a 'good response to treatment in a short time' may help differentiate between Pervasive Developmental Disorders and RAD. Shin et al (1999) reported that in their sample of children with disturbed attachment relationships but who presented with features associated with autism showed:

- a clearer capacity to build social relationships with 'non-deviant' adults;
- more social relatedness;
- relational difficulties that were more focused on mothers;
- ability to demonstrate emotionally interactive behaviours with staff that were different to those shown with their mothers; and
- social relatedness that was responsive to parent-child psychotherapy.

A more substantially concentrated source of information about overlapping phenomenology than these sources is available in the form of the Coventry Grid (Moran, 2015). As the Coventry Grid has direct relevance to a research question of the current study, a more detailed exploration follows so that the reader is positioned more clearly in relation to topics discussed later within the findings chapter.

The group who devised the first Coventry Grid was multidisciplinary: clinical psychology; speech and language therapy; social work; mental health nursing; occupational therapy; art therapy; and psychiatry from across 2 existing teams: the CAMHS attachment interest group and the CAMHS neurodevelopmental team. The means of constructing the Coventry Grid was through this multi-

disciplinary discussion group. The article does not say how often or for how long they met, so it is not clear whether, for example, this was 10 or 100 hours of clinical discussion. The themes were identified by discussing first the common day to day problems experienced by families of children on the spectrum and then by considering how these symptoms presented in children with attachment problems. The paper does not include details of the specific training or length of specifically relevant experience of the individuals participating in the discussion groups. Wider consideration of the drafted grid was invited through Educational and Clinical Psychology forums and through other local partners who were closely involved in delivering services to children with autism. The second version of the Coventry Grid was produced following contributions from a London/South of England group of speech & language therapists who work in youth justice and after discussions with professionals at CPD sessions about particular parts of the grid. Moran reports that there are no major revisions to the original grid; there are some additional descriptors and some small changes to descriptors.

Moran herself is an EP by training and practises as a Clinical Psychologist. She is a parent to adoptive children who were themselves questioned for ASD diagnostic assessment. She describes it as problematic to determine whether a child has attachment difficulties or autism, or both, when a child has experienced a very difficult early life or serious abuse or trauma. Based in the West Midlands, she devised the Coventry Grid<sup>6</sup>, the purpose of which is to help identify differences between the groups of children (those with autism and those with significant attachment problems) and therefore with differential diagnosis (p45).

In explaining the scope of the Coventry Grid, Moran uses the phrase 'attachment problems' and signposts that 'problem' is used as shorthand to refer to all kinds of 'significant attachment difficulties, severe enough to affect the ability to develop mutually supportive relationships with family members and friends' (p45). The paper is not specific or restrictive about the nature of the

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<sup>6</sup> The findings chapter will present a modified version of the Coventry Grid Version 2 based on the contribution of volunteers in the current study.

attachment problems i.e. which pattern of attachment is being eluded too. In the text, examples of behaviours given might be considered more reflective of Type C, and D or A/C patterns as a reactive type are described and an associated intermittent inconsistent and disruptive care by parents is described. At other times Type A patterns can be discerned. The term 'borderline' used within the paper is perhaps suggestive of edge or boundary aligned with a classification system might be better substituted for or understood as 'overlap' to convey a sense of shared territory rather than distinction. The 'borderline' issue might further be helped if future refinements could make it clearer which attachment pattern(s) overlap with what aspects of autistic symptomatology.

The opening of the paper includes reference to adverse early life experiences, which diagnostically are a prerequisite for attachment disorders. However, attachment patterns that present as less adaptive can arise out of seemingly innocuous or superficially appropriate life circumstances (Laing and Esterson, 1970) that may well not have come to the attention of services. This may be particularly relevant for Crittenden's Type As (compulsively compliant, compulsive caregiving). Moran does not specifically mention attachment problems arising through more mundane or everyday means (separation through illness, work, neonatal complications or the developmental or communication difficulties of the child). She does however, refer to the long term adverse effects relationally of disturbed early relationships, "...even when the children have not had hugely disrupted care history or been severely physically deprived" (p45).

Professionals involved in the production of the Coventry Grid were concerned about the long term accuracy of their diagnoses and what effect this might have on the effectiveness of support and treatment. Moran (2010) indicates that some types of intervention might help both autism and attachment problems e.g. visual timetables to reduce anxiety, but does not point to an established evidence base that the two 'conditions' respond to the same treatments or interventions in either the short or longer term. Indeed, she states that the substantial clinical experience of the Coventry Service (700 families over 15 years in the area of autism work, alongside developing more targeted

services for children and adolescents with attachment difficulties) has found that intervention could be quite similar in some cases, but needs to be quite different in others. In her paper in 2012, however, Moran notes,

“The way we might help a child will depend heavily upon our professional construction of their difficulties, with diagnosis being an important signpost rather than a destination. The best way to start intervening will be quite different for a child with ASD compared with a child with attachment problems. For both, an important aspect will be to reduce the social demands and to increase the structure in their day. For the child with ASD... [a key worker] will not usually need to be based upon closeness because most children with ASD will have other people they have close relationships with. The relationship will have a more practical focus, as an enabler rather than a therapist. For a child with attachment difficulties, the arrangements will usually involve a key worker who will try to offer unconditional regard” (p17).

It is sometimes not clear whether the Coventry Grid intends to be a compilation of differences in observable presentation (phenotype) as it purports or whether it intends to be a broader document where clinical impression is recognised as an important contribution: ‘clinical impression’; feel; and interpretation about functionality of behaviour and descriptions of observable phenomenology currently sit side by side. This observation has specific relevance to the current study where EPs’ talk about intuition and experience.

The contribution of the Coventry grid is the substantial clinical experience collated into a cogent document of observable phenomena providing an account of ‘content’. It does not provide an account of the process by which professionals might apply this volume.

#### 4.4.2 Existing recommendations about the process of differential diagnostic assessment

Good practice guidelines relating to the diagnostic assessment of autism have been produced in a number of countries, for example, England (NICE 2011), Scotland (SIGN 2016) and further afield in New Zealand (Ministry of Health 2016). In England, the NICE guidelines advocate for a multi-agency approach to assessment, and make suggestions as to the range of contributing professions; Clinical and / or Educational Psychologists are included. Bartolo’s (1999) PhD thesis presents an exploratory

study, the purpose of which was to identify and describe the frameworks used by professionals to make judgements and decisions within such multi-agency contexts. This study revealed assessment biases of the disciplines who contribute to diagnostic assessments and discussions. A group of health professionals (paediatric senior registrar, a clinical psychologist) applied knowledge frameworks mainly within the 'disease' model, whilst another, multi-agency group (managed by an Educational Psychology Service and including educational psychologists, a psychotherapist and the deputy head of a special school) were more likely to apply psychodynamic' and 'behavioural' models. The study also highlighted that whilst a common procedural framework for both groups of professionals included hypothesis testing and cycles of decision making, characteristics of that process varied relating to the different institutional contexts of each group. Essential components of professional contributions were, not only the expertise in the understanding of the specific type of disability they are assessing, but also the communication skills for effective professional-client interactions and inter-professional relationships.

With regard to attachment disorders, there are no universally accepted diagnostic protocols (Sheperis et al 2003) but by definition diagnosis is based on a problematic history of care and social relationships. NICE guidelines (2015) have also been published on the identification of attachment difficulties in children and young people. Although it covers attachment disorders too, it is clear to make the distinction between difficulty (such as insecure and disorganised patterns) and RAD and DSED (DSM 5) and RAD and Disinhibited attachment disorder (ICD 10). It includes that consideration should be given to the possibility of coexisting mental health problems, in which autism is listed as one. The guideline intimates that assessment falls in the domain of Health and Social Care, and speaks largely of the role of professionals in the care giving / edge of care system. Clinical experience in the region where this study was conducted is that children are very rarely diagnosed with attachment disorders and 'difficulties with attachment' are seen infrequently in correspondence

from the Child and Adolescent Mental Health Service. The assessment pathway advocates for the type of assessment approach advocated by Cohen (2010) and Goldstein (2002).

Scheeringa (2001) also speaks about the process of assessment. Scheeringa (2001) reviews 7 childhood disorders that include impaired reciprocal interaction and have clinical presentations that may seem 'autistic-like' but do not meet the criteria for autism spectrum disorders in order to help clinicians through the different diagnostic decisions. He describes 2 traditions in classifying clinical phenotypes: one which involves clearly operationalised criteria of a behavioural phenotype without theoretical or aetiological bases (Multiplex developmental disorder, schizoid personality disorder, PDD-NOS) and a second diagnostic tradition of identifying primary aetiological deficit, often developmentally based, that secondarily leads to a behavioural phenotype (multisystem developmental disorder, nonverbal learning disability syndrome, semantic pragmatic disorder and attachment disorders). In his comparison with attachment disorders, he summarises that those with attachment disorders can show improvements in socio-emotional functioning when care circumstances (being placed with nurturing caregivers) are improved i.e. the capacity for 'normal' relational skills is usually apparent in nurturing contexts. Differential assessment, therefore, is best served by assessment over time allowing a period of intervention to improve the caregiving context.

The Coventry Grid, which has already been introduced as a compilation of ideas about 'what to look [out] for', is complemented by the work of Overton et al (2007). They examined the process of professionals involved and thereby provide another link with the current study, albeit at the point of differential diagnostic decision making, rather than at the individual case work stage. Researchers at Texas University reviewed 28 children referred for differential diagnosis and found that a high proportion (79%) had been made using brief clinical interviews or partial evaluations that relied heavily on indirect measures, sometimes without even seeing the child. The approach to assessment by clinicians is commented upon with concern by EPs in the current study and is discussed in the

findings chapter. Overton et al (2007) then re-evaluated the children using comprehensive direct (ADOS, observation in class and other setting) and indirect methods (parent interview, parent and teacher rating forms) of assessment across domains in multiple settings. Then, using a qualitative approach examined how the decision making process used for differential diagnosis for this specific cohort of children (i.e. Hispanic) had been completed. The culmination of the study was the design (but not 'field testing') of three 'decision trees' for clinicians to work through to arrive at a differential diagnosis (one for differential diagnosis of PDD-NOS, one for ruling out communication disorder, developmental delay or mental retardation, and a final one for differential consideration of other disorders (anxiety, depression, ADHD, ODD, thought disorder). The researchers acknowledge that the clinical sample was small (n=28) and that the decision trees were based on what professionals had actually done, not on an evidence base of whether what they did was a valid decision making process and that future research should be conducted to evaluate the decision-making process.

The critical component identified in the decision making processes was the child's ability and capacity to relate voluntarily to the social overtures of others and to initiate spontaneous social overtures towards others. The concept of social impairment, as indicated by the child's involuntary inability to interact socially, was therefore, the core feature used to distinguish between children with and without autism. Moreover, the level of social impairment was considered when making distinctions between autism, Asperger's and PDD-NOS. Children without autism can still present with social difficulties due to other reasons (depression, anxiety, mental retardation or communication difficulties). They concluded a number of things:

- differential diagnosis is best when the use of the ADOS and the ADI-R are combined (the ADI-R not considered as sensitive as it is based solely on memory of parents on an entire developmental period and parents find it difficult to recall accurately and specifically years after the event);
- diagnostic process is influenced by developmental issues that are evidenced in ASDs such as age of onset, manifestation of symptoms, regression following typical development, age of children when parent becomes aware of possible developmental problems; and



- that it can take months / years to confirm a diagnosis.

The authors are transparent that the resultant decision trees are maps of professional decision-making as occurred, rather than field tested as good practice. The decision trees illustrated that issues around sleep, irritability and eating had been positioned around consideration of 'depression'. Some consider these areas the developmental tasks of infancy (to eat well, sleep well and soothe well), rather than an indication of pathology (National Research Council and Institute of Medicine, 2000). In addition, clinical experience informs that these are often areas of challenge for parenting children who subsequently become diagnosed with autism. Nonetheless, the study provides an interesting examination of professional activity in a targeted domain; differential diagnosis.

The purpose of Shin et al's paper (1999) is not to make claims about the process of differential decision making but examination of their work shows that a range of activities combined to inform their clinical impression: extensive interviews with mothers / family members to clarify caregiving history, maternal experience of parenting and attitudes towards child-rearing, maternal mental health before and during pregnancy, and after childbirth; observation and comparison of child interactions with caregivers and professionals; observation and comparison of play with caregivers and professionals; taking developmental histories; undertaking cognitive assessment and appraisal of language skills; and the use of a modified Strange Situation Test procedure.

In addition to good practice guidelines, numerous tools have been constructed to assist with collating evidence of the autistic phenotype and of providing information pertinent to diagnostic assessment. Some have been subject to research about their reliability. This thesis will not present an account of that research as it is outside of the main interests of the current study. It is important to note however, and is of relevance to the findings chapter, that the use of tools in assessment considered 'gold standard' by some (such as the Autism Diagnostic Observation Schedule, Lord et al 1999) is questioned as an ecologically valid assessment by others. As a constructed series of tasks,

conducted often by unfamiliar staff in a clinical environment, it purports to be a reliable and valid indication of an individual's functioning in certain domains in other settings. Some might contend that astute clinical observations within more everyday environments are more valid and reliable. As children change rapidly and are highly susceptible to changes in social setting, there are significant implications for diagnosis. Goldstein (2002) offers a view on good quality diagnostic practice relating to children,

“most clinicians forget that questionnaires do not diagnose... and the most ecologically valid means of understanding the development and behaviour of any child is the collection of data in multiple settings over an extended period of time” (p 611).

Cosgrove and Regier's (2009) very similar concerns about an overreliance on 'tools' within psychiatric diagnosis were presented earlier in this chapter. In concluding that the 'PDDBI is useful in assisting in differential diagnosis of autism', Cohen et al (2010) advise that triangulation of evidence from multiple sources (parent and teacher ratings, or 'informant interviews' and clinical judgement based on direct observation and reviews of records and files) remain crucial for diagnosis and cannot be replaced by a tool. Ventola et al (2007) suggest that 'judgement by experienced clinicians is considered "gold standard" for autism diagnosis'.

#### 4.5 Psychological Formulation and assessment by professionals

Given the difficulties with psychiatric diagnosis, and diagnostic manuals being analogous to a Rough Guide to a land barely explored, one is left to consider the viable alternatives to the current system. The Division of Clinical Psychology (DCP) (BPS 2012) drew up a position statement in relation to functional psychiatric diagnoses claiming that there needed to be a shift away from the predominating 'disease' model.

“Effective medical diagnosis (classification) requires a reliable and valid system for categorisation of clinical phenomena in order to: aid communication; select interventions; indicate aetiology; predict outcomes; and provide a basis for research” (p1).

The BPS position statement (BPS 2012) goes on to introduce the idea of psychological formulation,

“irrespective of whether the psychiatric diagnosis refers to a condition with an established primary biological basis or not, there is clearly an identified role for psychological assessment, formulation and intervention in addressing psychosocial factors, taking into account the influences of biological contributions” (p2).

It continues that,

“Psychiatric diagnosis is often presented as an objective fact, but is, in essence, a clinical judgement based on observation and interpretation of behaviour and self-report, and thus subject to variation and bias” (p3).

Johnstone, who contributed to the preparation of the BPS’ response (2012) describes why psychiatric diagnoses are not a valid (do not have a sound basis in research) way of understanding the difficulties and distress people experience and discusses the extent to which psychological formulation could be an improved alternative approach (2014). She feels that psychological formulation helps escape the ‘brain or blame’, ‘chemistry or character’ trap [of psychiatric diagnosis] in understanding difficulties and informing a best way forward, and thereby provides an alternative to it. Johnstone (2014 b) does however point out,

“There is very little research looking at the question of validity, or whether case formulations are meaningfully related to a client’s presenting problems, for which reliability is a prerequisite. Nor is there any clear link between case formulation and improved outcome” (p 261).

Some contrasts could be inferred from Johnstone’s discussion of the practices of psychiatric diagnosis and psychological formulation, as practised by clinical psychologists, and these are offered here (Table 4) as they provide a relevant backdrop to the talk of EPs presented in the findings chapters of this thesis.

Psychiatric diagnosis	Psychological formulation
Is a core function outlined in the code of ethics for psychiatrists	Is part of the core training and work of clinical psychologists
Occurs in addition to / alongside the practice of psychiatric formulation	Can occur instead of (stands alone from) a psychiatric diagnosis, as well as in addition to
Making an expert judgement	Collaboration and allows for negotiation with the service user
Assessment of symptoms against criteria published in manuals	Use of psychologists' clinical and research knowledge and the service users' expertise in their own life to develop a shared understanding
Observable symptoms are a manifestation of, and used as an indication of, underlying illness	Observable behaviours are better understood as survival strategies
Conceptualises patients as having an illness with mainly biological causes	Conceptualises service users' difficulties as an understandable emotional response to life circumstances
A diagnosis, which may be revised to new or alternative diagnoses	A shared understanding, or narrative, which develops or evolves over time
	Draws attention to strengths

Table 4. A suggested contrast of psychiatric diagnosis and psychological formulation.

For Johnstone (2014) “best practice psychological formulation is, therefore, based on fundamentally different principles from psychiatric diagnosis” (p83).

Quoting from the professional guidelines about the practice of formulation, Johnstone (2014), summarises,

“should always be collaborative; respectful of service users' views about accuracy and helpfulness; expressed in ordinary and accessible language; culturally sensitive; aware of the possible role of trauma; non blaming; and inclusive of strengths and achievements. Psychologists are expected to take a thoughtful and reflective stance which reduces the risk of formulation in insensitive, non-consenting or disempowering ways. There is a strong emphasis on the wider context of formulation, including recognising the possible role of services in compounding difficulties and having a critical awareness of the wider societal context within which formulation takes place” (p82).

Psychological formulation, as described above, is a core competency of the profession of clinical psychology and was first introduced in clinical psychology regulations in 1969. Good practice guidelines have been produced (BPS, 2011) for clinical psychologists. It is striking that within a good practice document, some considerable time (a whole section) is spent outlining the lack of universally agreed definition. Definitions of what formulation is incorporate the word hypothesis, (BPS 2011, p6) and permeate the various definitions quoted by Johnstone (2014 b). Hypothesis is perhaps a word which is more commonly used by educational psychologists, who are also noted within the Health and Care Professions Council (HCPC) regulations as practising formulation.

Hypotheses are created through a process of problem analysis.

“Problem analysis is a process by which information is structured and analysed in a way which facilitates its understanding by both client and EP (Monsen et al 1998, p238).

“EPs seek a plausible and logical representation of a problem which has a higher probability than others of providing a ‘best-fit’, encapsulating the ‘facts of the case’ and leading to a clear intervention plan” (Monsen et al 1998, p239).

The British Psychological Society (2006) views problem analysis as part of the core curriculum for trainees in Educational Psychology and this activity has been subject to study before. EPs work with a variety of clients, across a range of settings and an effective problem solving framework needs to accommodate this diversity and the highly individual problems that are raised with them. Kelly (2008) proposes that a practice framework can be “conceptualised as a structure involving a set of parts that sit or work together... a series of steps, stages, or actions that support the application of a theoretical model or models” (p18)– and enables practitioners to bridge the gap between theory and affective application of the theory in context (i.e. practice). The Monsen et al (1998) and Woolfson et al (2003) frameworks are posited by Kelly (2008) as “the 2 clearest examples of ‘overarching’ or ‘executive’ frameworks [*as opposed to theoretical models of frameworks*] which would enable a practitioner or trainee to elucidate and articulate their reasoning and justify

interventions” (p16)[ my addition]. Monsen et al (1998) developed the Problem Analysis Framework (PAF) for use by Trainee Educational Psychologists to help them:

- impose meaning on the messy problems presented to them by service users by enabling them to structure their ‘method cycle’ of integrating consultation, other sources of information gathering, analysis and interpretation of information gathered;
- undertake process collaboratively with service users, including children themselves, to develop an understanding of the interactions of individual and contextual factors; and
- develop cogent and justifiable proposals for intervention to address identified needs.

Kelly (2008) summarises that the PAF (Monsen et al 1998) (p19) addresses the complexity of the issues presented to EPs via a process of disconfirming hypotheses, and as an ‘executive framework’; it aims to ensure that interventions (actions) are focused and effective, with psychological theories and models emerging from the use of the framework, as they arise in situation specific circumstances. Woolfson et al (2003) later adapted this to form the Integrated Framework (IF), for use by experienced EPs. Woolfson et al’s (2003) IF aims to provide a “user-friendly conceptual framework for use by experienced EPs and to promote accountability and transparency of procedures” (p283). The nine steps of Monsen et al’s (1998) PAF are shown in Figure 3 alongside the 5 phases of the IF (2003) (p289).

<b>Monsen et al's (1998) Problem Analysis Framework</b>	<b>Woolfson et al's (2003) Integrated Framework</b>
<b>Step 1</b> Clarify the request and check out the need for EP input  <b>Step 2</b> Negotiate and Contract role	<b>Phase 1</b>  Establishing roles and expectations
<b>Step 3</b> Develop guiding hypotheses and gather information	<b>Phase 2</b>  Guiding hypotheses and information gathering
<b>Step 4</b> Identify problem dimensions  <b>Step 5</b> Integration of problem dimensions	<b>Phase 3</b>  Joint problem analysis
<b>Step 6</b> Feedback, agree problem analysis and devise intervention plans  <b>Step 7</b> Agree intervention plans	<b>Phase 4</b>  Joint action plan and implementation
<b>Step 8</b> Evaluate actions  <b>Step 9</b> Self-reflection and critical evaluation	<b>Phase 5</b>  Evaluate, reflect and monitor

Figure 3. Overview of Monsen et al's PAF (1998) and Woolfson's IF (2003).

Monsen and Frederickson (2008), highlight that most of the situations raised for EP involvement,

“require considerable amounts of prior specialist knowledge in order to work effectively with them...[and] can be seen to be ill-structured in nature...more complex, have fewer definite criteria for deciding if a solution has been reached and lack complete information” (p75).

Formulation of initial hypotheses and their testing is a strategy employed to help with these complex, and ill-defined situations. Schemata or ‘content guides’ (developed thorough experience and other forms of knowledge) “serve as reservoirs for hypotheses that can be called upon” (p79) during the hypothesis testing process to help practitioners make more accurate interpretations (Monsen and Frederickson, 2008). These problem analysis frameworks are perhaps best illuminated

when considered within the contexts in which they are applied. The findings chapter will refer to examples of espoused practice of problem analysis and hypothesis generation in EPs' accounts.

#### 4.6. Concluding the literature review chapters

The literature base concerning autism is vast and the literature review chapter has focused on aspects particularly pertinent to the current study: how autism is understood or conceptualised, including points of disagreement. The literature around attachment has had a focus on identifying stability of attachments patterns cross time and patterns of attachment across cultures. The application of attachment theory to understanding later developmental outcomes and the nature of the effects of early adverse relational experiences have been indicated. Literature concerning an apparent overlapping phenomenology of these effects and autism, and the challenges raised by differential diagnosis, is comparatively much smaller. EPs are one of the professions noted in good practice clinical guidelines who may be involved in this work. Two examples are provided of problem solving frameworks developed specifically to support the rigour of EP practice when faced with 'ill defined' problems. This study explores EPs' conceptualisations of autism and attachment and the overlapping phenomenology, and explores their experiences of the process of problem analysis within which they generate and gather data to assess the validity of alternative hypotheses, of autism or attachment difficulties, in their generic, school-based work; a specifically defined topic area that has not been studied previously.



## CHAPTER 5

### METHODOLOGY: ETHICAL, CONCEPTUAL AND PRGAMATIC CONSIDERATIONS INFLUENCING CHOICE OF METHODOLOGY AND METHOD

#### 5.1 Chapter Introduction

This study is oriented to a social constructionist perspective. It employs an iterative interview method and employs deductive and inductive thematic analytic methods.

The first chapter (5.1 – 5.4) addresses the key areas of decision-making that informed the design of the current study. The intention is that in providing this detail about decision-making, it enables the reader to conceptualise the study's design before proceeding to the second methodology chapter. Subsections 5.1.1 – 5.1.4 address the products and processes of the research, the choice of a qualitative method, and ethical considerations. Subsections 5.2.1 – 5.2.6 concern themselves with various issues related to the use of interviews as the method of enquiry. Subsections 5.3.1 – 5.3.3 concern themselves with choices related to the method of analysis. The final Subsection 5.4 discusses the how the 'end product' of interviews is conceptualised. The second chapter (chapter 6) then informs the reader about the procedural aspects of the research design; the methods of, and steps in, data collection and data analysis.

The key methodological decision making steps within the research design process are shown next schematically as a coherence cascade (Figure 4). The sections that follow will speak in more detail to those key decision-making steps, to establish the conceptual and procedural coherence of the research.

Product of Interpretative knowledge	5.1.1
Qualitative methods	5.1.2
Social Constructionist	5.1.3
Ethical Considerations	5.1.4
Choosing and conceptualising Interviews	5.2.1
Group                      Individual	5.2.2
Nature of relationship between interviewer & interviewee	5.2.3
Nature of interviewer role and behaviour	5.2.4
Structured, semi or non-structured interviews	5.2.5
Designing interview guide and types of questioning	5.2.6
Recording and transcription	5.3.1
Analytic choices	5.3.2
Thematic analysis	5.3.3
Conceptualising the 'end product'	5.4.

Figure 4. Coherence Cascade of key conceptual and procedural decision making points

### 5.1.1 The products and processes of the research

I had initially planned to explore questions around the practice of differential diagnosis with core group members of the local multi- agency autism diagnostic team, but this became pragmatically difficult because of the effects of stringent funding cuts disrupting the composition of the clinical team. I therefore, re-focused my research questions and reconsidered who the participants might be. In doing so, my thinking came full circle to the original phenomenon of my interest: EPs' problem- solving and decision-making processes. Exploration of EP problem solving has been subject to study before. Monsen et al (1998) developed the Problem Analysis Framework (PAF) for use by Trainee Educational Psychologists and Woolfson et al (2003) adapted this to form the Integrated Framework (IF) for use by experienced EPs. The aim of developing those frameworks was to ensure that EP interventions are focused and effective (Monsen et al 1998) and to promote accountability and transparency of procedures and justification of problem solving activity (Woolfson et al 2003). This study focuses on the experiences of EPs engaging in processes of problem analysis within which they generate and gather data to assess the validity of alternative hypotheses, relating to the nature and / or aetiology of needs, which may reflect attachment difficulties or autism, in their generic, school-based work. This specific topic area defined here has not been studied previously. The current study, therefore, offers contributions to the research about EPs' experiences of problem analysis processes and to existing literature concerning the apparent overlap of attachment-related and autism spectrum- related behaviours and how these presentations are explored and differentiated by a specific group of professionals.

The purpose of this study was not to test hypotheses. Rather it was to explore EPs' accounts of their practice within a particular domain. It therefore sought to generate an 'interpretative' kind of knowledge, with a practical focus on understanding. Seeking an understanding of another's perspective aligns with a subjectivist ontology and an interpretive epistemology. Whilst the area of interest for my thesis was established relatively early on in my Doctorate programme (with the initial

stimulus afforded by pre-doctoral experience), my thinking about how to explore it emerged over a longer period and through engagement with a number of activities. These included reading texts on research methods, reviewing the assignments that I had completed during my Doctorate programme and reviewing the research ideas recorded over the previous five years in my reflective journal. I noticed certain themes about my own research orientation and interests, including:

- a case work stimulus to many of my interests –the location or origin of my ideas in the practical realm and with linking practice to theory;
- focus on exploration to achieve understanding;
- focus on the particular case / situation and not in large scale generalisability;
- preference for ‘finding out what is there’ whilst acknowledging the ‘particular’ aspects of a context;
- preference for conceptual frameworks to give shape and structure to my understanding; and
- a concern about rigour and subjectivity.

Overall, these themes combined to position me as a researcher within a relativist or constructionist ontological orientation, and aligned me with a subjectivist epistemological approach and with a robust qualitative and interpretative, methodology. Given this is the first study with this aim, and there is not an existing body of work with which to compare methodologies, this study takes up Molloy’s (2002) invitation to introduce a non-essentialist, paradigm into clinical research. Choosing a constructionist approach facilitates insight into how individuals conceptualise their knowledge and practice. A constructionist approach also resonates with the interactional dimension and the importance of the role played by communication and interpretation in both the ‘display’ of attachment patterns and in the outward presentation of autism. Such a position is fit for exploring the planned research questions (which are provided at the end of Chapter 6) and for addressing the other aspects of talk that were identified during analysis for further examination as part of this thesis.

### 5.1.2 The pertinence of qualitative methods

This section explains that a qualitative method was considered most appropriate. Rowbottom and Aiston (2006) expose the myth of scientific method and argue that as inquiry is “multi-faceted” we should look for “fitness for purpose” (p154). Mellor (2009) encourages us to “craft our very own tools” (p93). I sought a method that:

- was fit for purpose i.e. appropriate in addressing the research questions;
- was defensible in terms of its position relative to previous pertinent work;
- addressed practicalities as described by Punch (1998) i.e. shaping and constraining factors such as, “How long I’ve got?” and “What resources (people, texts) have I got access to?”; and
- met relevant ethical standards.

According to Silverman (2011), qualitative methods are to be favoured if one is interested in exploring people’s behaviour, thoughts, and feelings about a particular phenomenon. The aim of this study was to gain a better understanding of (or a feel of), not a ‘measure of’ EPs’ behaviour. The aspiration was to ask and be able to answer ‘what’ and ‘how’ questions, and to explore phenomena in detail, at a local level. The study was not concerned with seeking to generalise results on a larger scale. Silverman (2011, p17) states that the strengths of qualitative research are a) its ability to describe how a phenomenon is locally constituted i.e. its contextual sensitivity and b) that it can use naturally occurring ‘data’.

I judged, therefore, that the research aims of this study were best suited to qualitative methods.

### 5.1.3 The pertinence of Social Constructionism

I considered that the process of having dedicated time to talk with EPs about their professional activity in a specific area of practice in a focused way might provide participating EPs an opportunity to more clearly and / or explicitly articulate their thinking for the first time. I anticipated that EPs might benefit from more than one discussion to offer an account that they felt satisfactorily captured their practice. I also expected that the very activity of engaging in conversations about their activity would facilitate the processes outlined by McCormack (2000) of theorising (actively

processing whilst recollecting and reflecting), augmenting (adding further pieces of information as conversation unfolds and stimulates recollection of other pieces), argumentation (add other information to add meaning) and describing (adding descriptions). In doing so, EPs' views of their activity would change as I worked and talked with them. In this way, the social enactment of conversation would generate an account of hitherto private, perhaps incompletely formulated self-regulated practice.

From a positivist perspective, there is a concern with what is real in responses. Responses in interviews are:

- a) reliant on memory of past events;
- b) subject to conventionalisation (recalled in the context of what was typical of the time);  
and
- c) re-told in light of subsequent events / contemporary theories (i.e. at time of interview).

That is, responses are a re-collection of what volunteers did then, informed by the hindsight of what they know now. This does not, however, undermine the quality of interview research from a social constructionist perspective. Social constructionism insists a critical stance is taken towards our 'taken for granted ways of understanding the world, including ourselves' (Burr 2003 p3). Within social constructionism, there are no objective facts or objective ways of reporting on a reality, and society is seen as both constitutive of, and constructed by, people. It is therefore in opposition to the positivism and empiricism of traditional science.

Social constructionism is described by Kelly (2008) as a "theoretical model that is immensely broad and complex, deriving originally not from psychology but from the sociological theory of knowledge" (p20). This school of thought proposes that a concept or practice that "may appear to be natural, objective and valid to those who accept it, but which in reality, is an invention or artefact of a particular culture / society. Social Constructionism is about dynamic and transactional models of shared, or negotiable, meaning – as opposed to static and objective models - of social and interpersonal experience. Speaking specifically about the profession of Educational Psychology, Kelly

(2008) states that Social Constructionism has “provided the major impetus for professional change in the last 30 years” (p20).

Using a social constructionist perspective of the researcher’s [my own] active role and analytic lens thus helps me in this study to manage issues of subjectivity. Social constructionism does not try to manage, limit or acknowledge subjectivity (or bias) like an uncontrolled variable, in the way researchers within a positivist paradigm might. Social constructionists acknowledge interpretation as part of, and as un-detachable from the research and interview process. With specific regard to the interview process,

“all interviews are active, regardless of how neutral the interviewers and cooperative the respondents. No matter how hard interviewers try to restrain their presence in the interview exchange and no matter how forthright interviewees are in offering their views, these are interactional accomplishments rather than neutral communicative grounds” (Gubrium and Holstein 2011, p150).

Adopting a constructionist perspective that attachment patterns and autism are also social constructions allows me to accept that EPs may well have varying understandings about the nature of these phenomena. It also confers the advantage that I am able, then, to work with EPs of varying conceptual schools without somehow undermining the ‘quality’ or ‘validity’ of my study. Individual perspectives are considered as wholly worthy of analysis.

Silverman (2011) suggests a social constructionist analysis would seek to elicit participants’ definitions of terms, situations, and events and try to tap into their assumptions, implicit meanings and tacit rules. The research questions addressed in the current study are both of a ‘how’ and ‘what’ nature, constructing accounts of how and what EPs think and do in a particularly defined situation. This intention is suggestive of the fit of a social constructionist approach and, I argue, of a face-to-face, collaborative and iterative approach to data collection and analysis, as opposed to a more detached questionnaire or survey method.

My position is that there is value in exploring what grows during the interview process as ‘content’, as well as being mindful of the conversational practices (context) that enable that content to grow. I too, would

“argue against the dualistic imperative to classify them (interviews) as one or the other. All we sociologists have are stories. Some come from other people, some from us, some from our interactions with others. What matters is to understand how we can put them to honest and intelligent use in theorising about social life” (Miller and Glassner 2004, p138).

It is not necessarily, therefore, a contradiction to study both identities and practices, as they depend on each other.

Berger and Luckmann (1966) view knowledge as comprising the scientific, the theoretical, and the constructed. Constructed forms of knowledge, they propose, are much more diverse and ‘larger’ than scientific and theoretical knowledges, and include customs, interpretations, routines, and processes. Reality is created by and between those members of a group or society, and institutional practices are accepted ways of being and interacting between actors within a group, and beliefs (understanding about what reality is) become embedded within that group. In this study, research is undertaken peer to peer, where the peers share features of habitas (professional training specific to a small group), so the research is a situated practice, with perhaps an increased likelihood of sharing language as institutionalised speakers in our discussion of constructed knowledge.

#### 5.1.4 Ethical Considerations

A range of sources (Willig 2001, BPS 2004 and 2010, BERA 2004, Milligan 2006, Wiles et al 2006, ESRC 2006 and 2011, and University of Birmingham 2011) informed the five main ethical considerations that were identified. Those considerations are set out next (a-e).



a) Informed consent and rights to withdraw consent

To ensure that all volunteers understood the process in which they would be engaged, the research was introduced orally, using briefing notes, at a team meeting or individually. A written information sheet was also provided. This dual approach of verbal introduction with opportunity to ask questions and the provision of written information satisfied conditions for voluntary and informed consent. Attached to the information sheet was a consent response section completed by those willing to take part. I retained a copy as the researcher. Volunteers retained a copy too.

The right to withdraw from the study was discussed at the initial phase when the study was outlined at the oral briefing. It was also detailed in the consent form. Consent was re-visited and re-affirmed throughout the period of active participation (whilst data collection was ongoing). Volunteers were informed of the point when their right to withdraw their consent was no longer possible (at the point of the first draft of the findings chapter having been submitted).

b) Secure data storage

All data was planned to be collected on work premises but some volunteers for matters of personal comfort or convenience chose their own homes (or mine). All interview recordings / written records were kept at my home in a locked filing cabinet when not in direct use. Electronic records (research data) were stored, in accordance with the University of Birmingham's protocols, on the University's network with back up copy on a personal encrypted USB. The USB was also kept in a locked filing cabinet. Data was gathered and maintained for the purposes of the research and the possible publication of parts of the research was discussed with each volunteer. In accordance with the University of Birmingham's research regulations, research data will kept for a period of 10 years.

c) Inability to guarantee volunteers' confidentiality and anonymity.

As researcher, I observed confidentiality during the research through routine aspects of professional EP conduct, such as not discussing volunteers' contributions with other EPs. Confidentiality was assured in these ways, unless volunteers opted to comment on their involvement in the research to others. Volunteers' names were not used in this study. For the purposes of data collection, analysis and reporting, each volunteer was assigned a numerical identifier in place of their name. Individual interview recordings/ transcripts were heard / seen only by the individual, the transcriber and myself. Confidentiality could be further safeguarded through a decision to omit some information from inclusion in the thesis, or by requesting that a copy of the thesis not be held by the University's e-resource / library.

As the study used a 'face to face' method of data collection (i.e. interviews), those taking part, and their responses were known to me as researcher, and were therefore not anonymous. In addition, parts of interview transcripts and quotes from transcripts could contain information that identifies individuals (which could not be predicted or circumvented, and in fact may be considered important parts of the analysis):

- are provided in the findings chapter or Appendices of the thesis where appropriate (which will be available via the university E-thesis resource);
- may appear in the research report provided for volunteers at the end of the study; and
- may be included in any publication of the research.

Non-participation of some EPs within the workplace may immediately highlight the identity of another. For example, when describing volunteers, if one of the trainees placed at the LA did not participate, this might identify, by default, the other trainee who did. All these features mean that guaranteeing anonymity was not feasible. Volunteers were informed of this prior to agreeing to take part.

d) Access to case files

At early stages of research design planning, my preference was for multiple data sources (data collection and analysis comprising two data sources; interview material and material from case files) in the belief that this would provide depth to the material gathered and thereby enhance the quality of the analysis. The LA's legal department viewed that personal data (about children and their families) held for 'work' purposes, either in active or archived files, could not be accessed for 'research' purposes because it contravened the Data Protection Act (1998). The process of requesting access and being denied, presented an opportunity to critically re-evaluate the ways in which other data sources might be seen to add value to that gathered via interview and to re-appraise the notion that more sources meant better data and how that sat with the espoused ontology and epistemology of the study. When consideration was given as to how case file material could have been incorporated into a data collection and analysis protocol, and therefore what was 'lost' by not having it, it became evident that its inclusion would have aligned more closely with a realist position than a social constructionist perspective,

"Realist triangulation refers to the use of multiple researchers, research methods, sources or theories in order to assess the consistency of findings. Results are understood to be substantiated where different perspectives converge so that triangulation becomes a process of mutual confirmation. The implication is that convergence provides evidence of accuracy and objectivity" (Madill et al 2000, p3).

This critical reflection enabled the consideration of an iterative approach to interview as an alternative, yet conceptually more coherent approach to achieving authenticity of data.

e) Integrating the roles of University of Birmingham Graduate Researcher with that of colleague / Senior EP within the employment context, and use of colleagues as research participants

Appraisal of possible detrimental effects of the study, their likelihood, the nature of their impact and my planned strategy for dealing with them are summarised in Table 5.

Table 5. Appraisal of Risks

Risks	Probability	Impact	Action
Disclosures of harmful/ illegal activity	Remote / very low	High	Need to be reported to PEP, and adhere to HCPC / Service policies
Child Protection issues e.g. neglectful practice and a lack of appropriate EP action disclosed during interview	Remote / very low	High	Need to be reported to PEP and adhere to Service, HCPC, and Local Safeguarding policies
Threats to occupational standing of volunteer	Low	Low to medium	Volunteer to bring to researcher or to supervision
Concern about 'volunteer – researcher' power differential	Low	Medium to high	Volunteer to bring to researcher or PEP if not satisfactorily resolved

The possibility of disclosures of harmful or illegal behaviour was considered a 'remote risk' as:

- all volunteers are EPs with enhanced CRB checks;
- all are subject to Health and Care Professions Council and British Psychology Society codes of professional conduct and ethical guidelines;
- all engage in regular line management / clinical supervision; and
- the interview process /content was to focus on working practices, not private activities.

This research, however, is no different from other research in that:

- any disclosures by volunteers of harmful/ illegal activity during the research process would need to be reported; and
- issues pertaining to the protection of children would always need to be prioritised over agreements of confidentiality.

In either of these latter circumstances, the planned action was firstly to approach the relevant EP colleague. She would then arrange a three-way supervision session with the PEP (who, through agreement did not take part in the study for this purpose), so that the issue could be appropriately addressed in line with Service, HCPC and Local Safeguarding policies.

Risks to volunteers inherent in this study were considered minimal because they:

- were not one of the vulnerable groups typically defined in the research ethics literature;
- were considered able to give informed, active and voluntary consent;
- were not required to undergo physically invasive or emotionally challenging procedures; and
- there were no elements of deception or coercion in this study.

It was possible however, that professional reflection stimulated by taking part in the study, and discussion amongst volunteers outside the formal research process, could have led to evaluative comparisons being made, with potential threats to an EP's occupational standing. A concerned EP would have been urged to bring this issue back to me as the researcher, or alternatively to formal supervision as preferred and supportive action agreed.

In addition, although the study aimed to be illuminative (rather than evaluative), and the approach to interviewing aimed to engender egalitarian collaboration, volunteers may have been concerned about a power differential. As the researcher, I was also their colleague, exploring an area of special interest in which professionally I have held a position of specialist responsibility. A concerned colleague would have been urged to bring this issue to me, in the first instance, so that it could be explored and supportive action agreed. Formal supervision would have been an appropriate next step should the colleague have felt that the issue remained unsatisfactorily resolved.

#### 5.2.1 Choosing to use interviews

Sections 5.2.1 to 5.2.6 orient the reader to my conceptualisations of a number of aspects related to the use of interviews in this study.

By the 1970s, interviewing was “taken for granted as an established practice in the survey world” (Platt 2012 p23). Despite this, there remains appropriate caution about it being positioned as a default method for qualitative research and concern that it has become “unnecessarily dominant as a research tool in qualitative psychology” (Smith 2005, p309). Some advocate, for example, that you should whenever possible, prioritise observation over interviewing, or combine both (Rapley 2012). In this study, observation was simply not practical, as it would rely on opportunities to occur naturalistically within a specified period, or feasible on ethical grounds, as it would necessarily include the focus child. In addition, the local authority’s Data Governance section had declined access to individuals’ files.

Another critical perspective of interviews as a research method highlighted by Gubrium and Holstein (2012) is that interviewers produce too much ‘noise’, which “pollutes our understanding of the phenomena that are at the centre of the research” and the noise is “almost too complex to manage, filter or put to one side” (p551). They go on to summarise a number of suggestions made by other writers: the decision to choose to do interviews should always be carefully made, always be second choice (rather than ‘flavour of the month’), and interviews should only be undertaken and analysed when a researcher cannot gain access to the phenomena by any other means (p551-2). I argue that there is an assumption implicit here that other methods of research do not make as much ‘noise’. What constitutes ‘noise’ also warrants some critical thinking. Whatever form data collection takes, noise could take the form of uncritical re-representation. Furthermore, an argument that ‘noise’ is generated through interview as a method of data collection is not perhaps as strong or compelling if an active role is privileged and acknowledged on behalf of the researcher and if social constructionism is used as the analytic lens.

In favour, Byrne (2004) describes the usefulness of interview methods,

“Qualitative interviewing is particularly useful as a research method for accessing individuals’ attitudes and values – things that cannot necessarily be observed or accommodated in a formal questionnaire. Open ended and flexible questions are likely to get a more considered response than closed questions and therefore provide better access to interviewees’ views, interpretation of events, understandings, experiences and opinions...qualitative interviewing when done well is able to achieve a level of depth and complexity that is not available to other, particularly survey based, approaches” (Byrne, 2004 p 182).

### 5.2.2 Conceptualising the interviews

An interview is a ‘purposeful interaction’ designed to elicit ‘data’ with the nature of the data depending on the ontological position of the research and the research questions. A constructionist view of interview interactions is that they are inherently spaces in which both speakers are constantly ‘doing analysis’; both speakers are engaged (and collaborating in) ‘making meaning’ and ‘producing knowledge’. The knowledge and meaning that are coproduced are therefore not contaminable and do not need to be avoided or acknowledged. In the current study, data is the talk about thoughts, emotions, and behaviours and the actively / contemporaneously occurring reflections. Charmaz and Bryant (2011) describe,

“Interviews are of course, retrospective accounts that often explain and justify behaviour. Yet they may also be special social spaces in which participants can reflect on the past and link it to the present and future in new ways. An interview is a performance, whether stories tumble out or are strategically calculated and enacted, but that does not disqualify interviews from providing rich data and sparking analytic insights” (p 299).

I drew on three interrelated givens from the social constructionist tradition discussed by Gubrium et al (2012) in designing and justifying my approach to interview. The three givens and their implications for the current study are presented in Box 4.

1. “*Given* that we have no direct access to what goes on inside people’s heads, we cannot assume that what people say in interviews is what people think” (p550) – social constructionism rejects the simple correlation between talk and essential meaning and talk is always only a representation of meaning. Therefore, the construction of knowledge between the interviewer and interviewees during the interactional process needs to acknowledge their ‘subject positions’ and their voices during the interview process.
2. “*Given* that we only have access to people’s accounts of events, we can only view what people say in interviews as one possible version” (p551) answers on one occasion may not replicate those on another because they emerge from different circumstances of production. The ‘interview outcomes’ then are considered as one story that could have emerged.
3. “*Given* that what people say is produced in and through interaction with an interviewer, we cannot assume that what they say in interviews has any relation to what they would say or do in other (i.e. non interview) contexts” (p551). The relationship between interview content and any ‘real’ experience is not merely unknown but in some senses unknowable” (Dingwall 1997, cited page 551).  
The products of interviews in this study are seen as “joint accomplishments” between the interviewer and interviewee rather than directly corresponding to the world beyond (p550).

Box 4. My interpretation and application of three givens from the social constructionist tradition discussed by Gubrium and Holstein (2012).

The rationale for interview as method in the current study is better viewed as striving to “grasp individuals’ meanings” and to enable interviewees to “convey situated experiential realities in terms that are locally comprehensible” i.e. their account on my topic, which they have come willingly to discuss (Gubrium and Holstein, 1995, p9).

### 5.2.3 Type of interview

The conversations that provided information for the purposes of this study arose from an interview design which sought, broadly, to meet the four common features of an interview discerned by Wang and Yan (2011, p231):

1. goal or task oriented talk to gather information;
2. a question – answer sequence is the predominant structure;
3. the interviewer and interviewee have their respective roles to play, the interviewer acts in the role of questioning and the interviewee in the role of answering; and
4. the interviewer is empowered to do the questioning; the interviewee is confined to the responding.



The individual interview format was chosen following consideration of the relative advantages and disadvantages (Denscombe 2007) when compared with group interviews, as shown in summary form in Table 6.

Table 6. My comparison of individual and group interviews.

Group interviews	Individual interviews
Quicker to interview all participants at once	More labour intensive to undertake on an individual basis
May get broader / wider ranging discussion if group mixes well	Depth and detail of individual account, which can be lost in group situations
Group dynamics introduce an additional dimension	Only immediate dynamics between interviewer and participant need to be managed.
Group dynamics may mean that individuals might be reluctant to share views	Participants may be more willing to share / be open about their views / experiences

#### 5.2.4 Conceptualisation of the nature of interviewer and interviewee relationship

What constitutes an appropriate methodology depends on the guiding paradigm so it is necessary to interpret the advice presented in standard texts.

“Further, differing methodologies carry with them differing values or ideologies. At times, we purchase control over variables at the price of secrecy and manipulation; other investigators wish to sacrifice control for more sensitive and caring engagement with those they wish to understand. Methods, no less than theory and data, contribute to cultural intelligibilities and forms of life” (Gergen 2001, p 15).

I propose that my researcher identity positions me quite differently to much of what is written about conducting interview research, where researchers have no prior or current knowledge of, or relationships with, respondents. Firstly, I occupy an insider position as I am of the same profession as the volunteers, so we may share a similar orientation to the topic area. Secondly, my pre-research position of colleague / former colleague, positions me differently with the volunteers. I therefore already have an (undefined) ‘rapport’ afforded by a level of familiarity with respondents and their field.

In essence, this research aimed to value the involvement of volunteers as equals in a non-hierarchical, non-exploitative relationship and therefore viewed the conversation between researcher and volunteer as an egalitarian exchange (Platt, 2012). What are referred to as 'pilot interviews' were conducted with two of six participating EPs, with whom I was most familiar, with the specific purpose of trying out an approach to questioning and seeking feedback about how it felt, and might feel for volunteers to take part. Their feedback was acted upon constructively to inform the design of a model for interviewing along the lines of a guided journey and exploration of the topic of study. In addition, the pilot phase particularly informed that adjustments would be made with regard to how the scene setting of subsequent interviews with other volunteers was managed. The pilot phase also enabled a reconsideration of the importance of the oral briefing and consent forms as the beginning of the relationship between myself and volunteers as researcher-volunteer, who also occupied relationships as colleagues or former colleagues. Further detail relating to these functions, and benefits, of the pilot phase in informing the research design, is provided in section 6.1.

The approach designed sought to parallel that described in an early reference (Bingham and Moore, 1931) (cited by Platt (2012, p20) :

- the focus being on 'rapport' and on the respondent feeling respected and appreciated;
- that respondents can see the value of collecting the data;
- that the interviewer has a right to ask it and the questions; and
- the direction of the interview is relevant to that.

Given that, "The aim of an interviewer is to allow / provide a space where 'very detailed and comprehensive talk' happens", and the "interviewer is central to the trajectories of interviewees' talk" (Rapley 2004, p22 and p26), I considered the extent to which I concurred with the positivist position in seeing participants as 'repositories of facts, reflections, opinions, and other traces of experiences' (Holstein and Gubrium, 2011 p152). I agree with this proposition to a certain extent, but diverge somewhat in holding a sense of participants' (called volunteers in this study) positions as

capable of evolution through the interactive process of conversations, and see the process of the interview more closely aligned with the account provided by Holstein and Gubrium (1995) in 'The Active Interview'. This posits that interviewees produce (construct) their own knowledge throughout their engagement with an iterative interview process.

I was able to consider Denzin's (1970) suggested sites of difficulty with interviews by purposefully seeking and acting on feedback from pilot interviews (Appendices D and F), as shown in Table 7.

Table 7. My response to Denzin's (1970) concerns about interviewer- interviewee interactions.

<b>Denzin's suggested difficulties with interviews</b>	<b>My response to feedback from pilot interviews</b>
Interviewees possessing different interactional roles from the interviewer	Explicitly addressing expectations of roles during the early stages of interviews
The relative status of interviewer and interviewee	Adjust my approach by addressing issues of identity and power explicitly during the early stages of interviews, hoping to 'out' unspoken white elephants
The problem of self-representation especially in the early stages of the interview*	Notice problems of self-representation during interviews and respond appropriately
Problems of volatile/ fleeting relationships to which respondents have little commitment and so 'can fabricate tales of self that belie the actual facts'*	An iterative approach facilitating a more sustained collaboration, hoping to foster authenticity
The difficulty penetrating the private worlds of experience	Hold in mind that volunteers were capable of choosing what to share and what to withhold  Adjusting my approach, so that my 'challenging and probing' default was held in check to allow 'stories' to be told before probing
The context of the interview (home, work, hospital)	Offer flexibility on an individual basis about location and timing of the interviews.

\*I propose that my prior and ongoing relationships with participating EPs reduced these potential difficulties.

### 5.2.5 The significance of my behaviour as interviewer

I was mindful of a number of features reported upon by Rapley (2012, p543-546), namely that my verbal and non-verbal behaviour as an interviewer could:

- implicitly, if unintentionally, contribute to the trajectory of talk by directing, inviting, or encouraging specific topics to either be elaborated upon or discontinued;
- work to encourage volunteers to be the kind of interviewee I wanted them to be (by encouraging some and discouraging other talk);
- act to close talk down as well as open it up; and
- encourage mutuality or highlight difference and contradictions.

Rapley (2012) suggests that proxy indicators of a 'good interview' could be as simple as 'feeling' that you both 'got on well', that you presented yourself well, that you got 'answers to your research questions', that interviewees gave great quotable responses or that their responses shed a new light on a topic. Roulston (2012, p61) states that,

"...what a good interview will look like will vary according to the epistemological and theoretical perspectives assumed by the researchers in the design and conduct of research projects".

Roulston (2012) goes on to suggest that,

"some researchers take the view that since interviewers use the very same conversational skills speakers use in ordinary conversation, interviewers simply need to be aware of how their conversational practices unfold in specific contexts with others, and learn to listen respectfully" (p63).

Rapley (2004) on the other hand, warns that "interviewing is never 'just a conversation', although it may be conversational" (p26).

In this study, interview products are considered co-constructed, so interviewer behaviour and question design become more salient. Rapley (2012) speaks of the value of analysing interview transcripts or audio recordings from the perspective of one's own contribution to the interview interaction encouraging reflection on one's own behaviour, providing substantial analytic insight, and potentially redirecting the researcher's overall approach. I adopted this orientation when I undertook my first two attempts at interviews with former colleagues, where the 'implications' of

'poorer interviewer performance' might not have been so dramatic. I used these colleagues' constructive feedback to inform my subsequent interview and question design.

In deciding what might be a 'good' approach to interviewing, Rapley (2012) (p549) poses the question, "why follow a specific style, format, tradition of interviewing?" (p549). He goes on,

"Our choices routinely emerge from our training, our intellectual habitus, and our disciplinary grounding. However, we do need to critically reflect on those diffuse legacies. For me, the only reason to prefer a specific style over another stems more from a desire to produce or enact a specific ideology, theory, or politics with just that interviewee" (p549).

My intended role as interviewer in the current study was to collaborate in the construction of accounts, rather than to distort, lead, or direct talk in a formulaic self-serving way. I wanted to be sure that my conclusions would not be based on my own prior assumptions and expectations. Such risks were checked for by collaborating with peers about the process of the interview, negotiating areas of talk, and ascertaining their preferences about the approach to talk. Reflexivity was also important when listening to audio recordings, being vigilant in my approach to questioning and the possibility that I was importing my views. Constructionist perspectives on interviewing were drawn on in the design of the interview guide, which is discussed next.

#### 5.2.6 Writing interview questions and structuring the interview guide

Platt (2012) similarly argues that choices about questioning should be in line with the work being done i.e. the nature of the research. For example, less structured questions would be helpful when the research aim is more about discovery than testing preconceived ideas. Rapley (2012) talks of two main types of literature that exist about how to structure questions and conduct interviews; either aligned with positivist or constructionist thinking. Table 8 provides a summary of those perspectives.

**Table 8. Positivist and Constructionist perspectives on interviewer behaviour and questioning**

<b>Positivist researchers</b>	<b>Constructionist researchers</b>
Aim to make themselves as neutral as possible by behaving in accordance with some sort of code of conduct or good practice interviewer behaviour guide (including reference to appropriate lexical designs, questions and awareness of physical comportment).	Align more closely with the active interviewer, permitting more engaged forms of interviewer behaviour.
Aspire to a sanitized interview process which is as uncontaminated as possible.	Claim experience is far too complex to be 'captured' in that way.
The data can hold independently of the research setting and the researcher.	Treat data as displays of perspectives from available cultural resources.
Use highly refined interview techniques, such as structured (if not standardised, predetermined) interview questions.	The data expresses interpretive procedures / conversational practices between interviewer and interviewee and interviews can be analysed from the perspective of the researcher's own conduct (instead of /as well as from the point of view of the data to be collected).
Claim that interviews could be treated as reports on external reality if using strict protocols.	Interviews provide data but accounts are representational and provisional.

He critically examines some taken for granted assumptions about what constitutes 'good interview question design' and proposes that a more useful way of understanding interview questions and gestures is to see them as 'devices' which aim to help (the interview process) in some way. With this positivist – constructionist dimension and notion of 'devices' in mind, I was concerned to design my interview question structure so that it encouraged collaboration in the production of talk that could then be subject to a thorough and systematic analysis, without 'skewing' the process with my own ideas, and achieved authenticity within a collaborative exchange.

In designing my interview and questioning approach, I combined ideas from a range of sources (chapters within Gubrium and Holstein's volume (2012) and (1995), Charmaz (2006) Kelly et al (2008), and feedback from 'pilot' interviews.

At the beginning of the interview, I made some considerable investment in 'setting the scene'. This was important as it situated my identity and that of the volunteers for the purpose of the interview

(at least their first / initial identity as identities can shift during the course of interviews). Scene setting behaviour is summarised in Table 9.

Table 9. Description of and rationale for scene setting in interview

<b>Decision</b>	<b>Rationale</b>
Asking EPs why they volunteered to take part	Thereby understanding levels of motivation to engage with the research– to learn something, more personal reasons, or more practical reasons (to add to HCPC CPD log) (Rapley, 2012, p544)
Explicitly stating my orientation to the research topic, namely that I hoped that our discussion would help create, challenge and inform my knowledge in this area	How the interviewer and interviewee position themselves is “central to the trajectory of talk” (Rapley, 2012, p544 and p550)
Orienting the volunteers to the topic of the forthcoming co-construction	So that talk was productively directed rather than leaving to chance that we might eventually engage in talk that addressed my planned research questions
Asking about their familiarity with taking part in and conducting research	To address aspects of identity and comfort
Explicitly raising the possibility of power differentials and seeking volunteer perspectives on this	To address ‘white elephants’ (Wang and Yan 2012,p233)
Explicitly raising my intended behaviour /role in the interview process	To ensure shared expectations and to be able to proceed in confidence
Outlining my intended approach to questioning	To ascertain whether my intentions fitted with their expectations of the process
Asking about their preferences for ‘zig zagging’ or order to the conversational flow	To best meet volunteers’ needs to enable talk to be most productive

Charmaz (2006) talks about preparing questions ahead of the interviews. I imported some of her ideas about structuring the progression of interview discussion (by employing adaptations of her opening, initial, intermediate and ending type questions) and being prepared with a form of wording that would enable me to avoid the pitfalls / criticism of being leading. Introductory questions were added, as noted above, before the initial questions suggested by Charmaz, to set the scene, ensure consent and topic and process familiarity, gauge expectations of the interview process, foster an atmosphere of embarking on something novel to both of us, and to acknowledge the stake on behalf of both parties. I also synthesised ideas from Kelly et al (2008) to structure questions to introduce

broad topics of talk: about the thoughts (theory), feelings (ideological) and behaviour (practice) of EPs.

Within the planned interview questions, there was some explicit orientation towards answering research questions, serving as a semi structured interview guide, rather than a more structured interview schedule, to be deployed indiscriminately in a fashion that risked strait-jacketing talk and authentic communication.

Wang and Yan (2012) illuminate the different types of questions (closed/ forced choice, direct, specific, open (non-direct and non-specific). The interview guide was structured by planned questions that used suggestive openers. I also used direct and specific types of question during interviews when I was seeking clarity that I had a shared understanding.

“When an interviewer asks a question, she or he restricts the topic of discussion to the extent that the addressee has to respond according to the question...Questions not only topicalize matters to which the interviewees should respond; the change in question also manipulates the shift of topic... Usually, the interviewer’s questions help the respondent talk topically...Therefore, the interviewer’s questions and the interviewee’s replies lead to conversational relevance and topical unity. In other words, the interviewer’s questions and the ensuing sequential topics produce narrative coherence in a conversation and will ultimately constitute a conversational topic as a whole” (Wang and Yan 2012, p236)

My aim was to elicit talk to address my research questions, which therefore was the ‘overarching topic’ of the interview. I intended that my contribution via questioning would ensure that a range of ‘mini topics’ that I judged salient to this inquiry, were coordinated within the broader topic and my larger research objectives.

I was mindful that some of the questions asked during the interview would not necessarily be planned at all, but rather responsive to talk as it progressed. Rapley (2012) talks of the subtlety and sophistication of successful interviewing.

“my fundamental task in interviews is to attempt to explore, with just that participant, his or her practical experience and knowledge about a specific topic or range of issues... my job [role] is to incite



the participant to speak and explore in some detail... more often you have to show the interviewee the kind of style, format and trajectory of talk you're interested in" (p549).

I anticipated that my role as interviewer would be of simultaneously managing the here and now interview talk with my research questions in mind, whilst remaining open to other lines of exploration as they became visible.

I explicitly align myself with an active interview process as described by Gubrium and Holstein (1995). Planned questions were directing to topic (without being leading in a biased kind of way) because volunteers had explicitly and knowingly come to take part with the purpose of exploring "their situated knowledge about a specific topic" (Rapley, 2012, p550). Together we created "an emergent knowledge" situated within a specific context of 'here and now interactional effects'.

### 5.3.1 Recording and transcribing of interviews

This section outlines a number of decisions I made about how data should be gathered and analysed. Decisions were informed by ontological claims about the nature of the transcript (Sandelowski 1994) and practical considerations about preparing data and transcription to facilitate the systematic organisation and analysis of textual data (McLellan et al 2003).

Interviews in the current study were audio recorded to:

- allow retrospective analysis outside of the arena of being 'present' and managing the encounter of the interview situation;
- allow repeated visits to the same material (whether or not transcribed too); and
- afford depth of and care in analysis.

Digital audio recording was favoured for superior sound quality and for easier / safer storage of data.

It also made for ease of transferring data electronically to a professional transcription service.

"Transcription is the process of turning sound (and video) recordings into written text prior to further analysis of the material... and is a time consuming process which is prone to errors" (Howitt 2013, p145).

A primary question posed by Sandelowski (1994) is whether transcription is necessary. I considered that transcription was necessary for the purposes of analysis in this research (which generated fifteen hours of interview talk). Howitt (2013) lists a number of benefits of transcription: transcripts provide a portable form of data; a primary focus of analysis; a means of communicating with other researchers; and a means of including data in publications. A number of points from Howitt's chapter and Green et al's paper (1997) were acknowledged in the current study:

- no transcript is ever is the same as the original spoken words on which it is based (as there are difficulties 'translating' what was said);
- transcripts are therefore never perfect and are produced for particular analytic purposes; and
- interpretation by the researcher plays a part in the production of the transcript.

I made a number of decisions with regard to transcription: who would do it, how much material would be transcribed, and what annotation would be used.

On whether to transcribe the interviews yourself or employ a professional transcription service, Rapley writes,

"I used to always transcribe the interview tapes myself....Increasingly my tapes have been sent to transcribers, which means I always check the transcript against the tape and add the sort of detail I'm often interested in... However, when it comes to periods of sustained analysis, I always prefer to re-listen to the tapes alongside re-reading the transcript. This allows me to get a sense of the interactional, collaborative, work of the speakers" (Rapley 2004, cited Silverman 2011, p203).

My perspective was that employing a professional transcription service removed the perfunctory administrative burden (labour) of the research process, but, as I engaged with transcripts and audio as Rapley describes above, I did not consider this to be at the expense of getting a 'feeling of the data'.

A decision also had to be made about how much of the data to transcribe.

“Never think of transcribing all your material at the start. Instead transcribe one or two examples and analyse those. You will then be in a far better position to decide how much of your material needs to be transcribed in full and how much can be transcribed at particular points of interest” (Silverman 2011, p59).

This perspective on the use of transcription is not in the spirit of co-construction. In addition, I wanted to work with volunteers’ accounts in the fullest possible sense, to avoid premature data reduction and analytic decisions. This study employed a method therefore, that audio recorded and transcribed the full length of all interviews with the aim of conferring a number of advantages to me as researcher, noted by Rapley. It intended to:

- preserve the detail / entirety of the discussions in full verbatim accounts;
- allow me to become familiar with the discussion material (via the process of transcription correction) in a way that it is not possible in the immediacy of the actual interviews;
- enable a deeper, and hopefully more secure, understanding of the interview content; and
- provide an opportunity to reflect on my role in the interview process and participation in the construction of accounts.

Additionally, Potter and Hepburn (2012) state that if certain interviewer behaviours are thought to be crucial in ‘how talk passes out’ (p560) then these behaviours should be made explicit (or at least available) to the reader. This is possible by retaining audio recordings and full verbatim transcripts.

Transcripts can be viewed as realist objects and as a reduced form of representation.

“The world never speaks directly to us but is always encoded via recording instruments like field notes and transcripts” (Silverman 2011, p166).

Howitt (2013) explains the cumulative levels of data reduction involved in using transcripts,

“Researchers need to appreciate that their data are not actually speech as such but transcriptions based on recordings (or video) of speech. The recording is less than or a reduction of the original interaction and the transcription is less than that recording” (p172).

Denzin (1991, cited by Silverman 2011) adds the problem of representation to the problem of data reduction,

“The subject is more than can be contained in a text, and a text is only a reproduction of what the subject has told us. What the subject tells us is itself something that has been shaped by prior cultural understandings. Most important, language, which is our window into the subject’s world (and our

world), plays tricks. It displaces the very thing it is supposed to represent, so that what is always given is a trace of other things, not the thing – lived experience – itself.” (Denzin 1991, p68).

In the current study, the combined challenges of data reduction and representation of using transcripts are perhaps eased by having been present and engaged in all of the interviews myself which enabled me to adopt a notation system judiciously. Drawing on the seven principles of developing transcription provided by Mergenthaler et al (1992), I wanted to use a method of annotation that:

- addressed the tension between wanting to simplify the research process, whilst being able to offer a thorough audit of my academic claims (Rapley, p561);
- allowed an ‘adequate’ evaluation by others;
- was not so cluttered it was indecipherable;
- achieved a balance between being so heavily annotated it impeded an understanding the themes discussed with being inadequately annotated in a way that a reader may not get a sense of the interaction that took place; and yet
- the annotation rules were simple, few and accessible.

Listening to audio recordings whilst looking at verbatim transcription enabled transcription annotation, which aimed to more or less adequately reflect as feasibly as possible what was going on at the time of recording (Hammersley 2010, cited Howitt 2013, p150).

Poland (2002) states that Jeffersonian transcription is the,

“...industry standard for doing conversation-analytic work. It relies on a quite specific series of notation devices to render various aspects of the interactional texture and can appear as an overly technical and complex way of textually reproducing talk. Clearly it is not for everyone, as few have the analytic interest, time, technical expertise, or budget to undertake such work” (Poland 2002, p547).

As the choice of transcript annotation depends on the types of analytic claims that a researcher seeks to make (Rapley 2012, p547), Jeffersonian transcription was not appropriate for the purposes of the current study. As an alternative approach more accessible to a novice analyst, Poland developed a useful list of things that he considered should be included in transcription: pauses, laughing, sighing, coughing, interruptions, overlapping talk, garbled talk, emphasis, held i.e. sustained sounds, reported speech, mimicking, paraphrasing of others and self-thoughts.

Rather than impose an existing notation system, I developed my method of annotation through practice, beginning with the first verbatim transcript and adding notation to things that seemed important in conveying the meaning of talk. Many of things I used were on Poland's list: pauses (but I made a distinction between pause and long pause), laughter, coughing, interruptions, inaudible, emphasis. I also noted slow speech as this seemed important in conveying either emphasis of feeling or that volunteers were deliberating or constructing their ideas as they spoke. I repeated this process with all other interviews and the method of notation was sufficient in my view for the current study. In producing the transcripts I:

- set out the interviewer and interviewee on separate lines to allow the reader a much clearer look at what went on during; and
- added line numbers to allow precision when referring to segments of talk so that analytic observations could be linked more specifically with elements of talk, not going direct to the quote but rather using 'talking beginning at line'... to indicate the embedded nature of the talk.

Howitt (2013) states that the 'insider-outsider dimension' is an important one that should be reflected upon by researchers as it has a bearing on the process of transcription (p 152). I judged my position as a relative insider, afforded me a greater level of 'accuracy' in the interpretative practice of transcription as:

- I was present in all of the interviews so had first-hand knowledge of the interactions;
- I knew all the volunteers so was familiar with their dialects and mannerisms;
- I was from within the same profession so had a knowledge of their language / terminology; and
- I was from within the region so was familiar with the local services / practices / personnel of which they spoke.

### 5.3.2 Data analysis

“In the process of analysis – whatever that is, as I’m not actually sure when analysis begins or starts – we are directed and inspired by a range of issues” (Rapley, 2012, p552).

Analysis in the current study was considered to be of two forms. One form was an integral part of the interview process; volunteers and I examining each other’s responses during each interview affecting, the trajectory of talk. A second took the form of a number of analytic activities outside of the interview setting. These included: listening to the audio recordings; correcting transcriptions; annotating transcriptions; reflection between individual interviews; making connections between interviews with different volunteers; and the ‘formal’ stage of analysis of transcripts, once interviews had ceased and transcripts had been annotated.

A further decision that required consideration was who and how would determine that an end to data collection was appropriate. I did this by asking volunteers to indicate whether ‘their story’ was at a point of fullness. Of six volunteers, five felt satisfied after two interviews and the other after three. I would argue that this process implicitly aligns with the espoused perspective on shared power and ownership of the co-construction process between the researcher and “the researched”.

“Frequently, a single incident noted by a perceptive observer contains the clue to an understanding of a phenomenon. If the social scientist becomes aware of this implication at a moment where he can still add to his material or exploit further the data he has already collected, he may considerably enrich the quality of his conclusions” (Selltiz et al 1964, Cited Silverman, 2011 p19).

Using an iterative approach to data collection meant that both the volunteers and I got the opportunity to re-visit discussion. This allowed me to ask clarifying questions, and allowed volunteers to reflect in the interim and respond to probes and requests for clarification. I suggest that this process better enabled volunteers to determine the point of fullness of and satisfaction with their account, than would have been afforded by a single interview. By suggesting that accounts were enriched by this iterative approach to co-construction, I argue that more comprehensive and authentic subject perspectives were realised. Once all volunteers were satisfied that further interviews were not necessary, all interview transcripts were analysed thematically.

### 5.3.3 The use of Thematic Analysis

As noted in section 5.1.1 I positioned this study within the ontological and epistemological realm of social constructionism. It was necessary to determine an analytic method that was congruent with this position and determining a best fit was a notable challenge. Various qualitative methods of exploring data were considered in terms of fitness for purpose in meeting the aims of the research and practicality. I expand some examples next.

Early exploration of possible analytic approaches included consideration of content and interpretive phenomenological analyses, ethnography, appreciative inquiry and grounded theory. Qualitative content analysis has roots in quantitative methods (Howitt 2013). It was interpreted as aligned with a realist position where talk is considered a more direct representation of manifest entities, than the interpretivist position taken in this study (Stratton 1997, Hsieh et al 2005). Ethnographical approaches typically imply extended and in depth contact with participants (Holloway 2003) and that the topic under investigation is readily observable simply by being 'alongside' and 'in amongst' them. Waiting for such material to arise within the framework of this research was not a practicable approach. These approaches also typically favour observation of action in naturally occurring settings, rather than interview, as data gathering and analytic choices. Appreciative Inquiry (Cooperrider 2008) places emphasis on change and development, implying that change in existing practice is possible, and desirable as a focus of study. The focus of the current study was to explore perspectives of current practice, and did not seek to facilitate change in existing practice. Interpretative Phenomenological Analysis (Smith et al 2009) does share some of the central concerns of my orientation to research:

- it is idiographic, not nomothetic, with an emphasis on the particular;
- it attempts depth of analysis to arrive at a sense of detail;
- it is thorough and systematic in its data collection and analysis; and
- it is relativist in its ontology.

Interpretative Phenomenological Analysis (IPA) is concerned with situations where 'an experience' is one of such importance, that a person invests time and energy reflecting on it to make sense of what has happened. This study is not about experiences that have immersed or consumed volunteers or necessarily engaged them reflectively on a regular basis. The research interest is not in the intensity of THE experience of volunteers per se. Rather, the research focus was on one, of many, topics that occupy the thinking of EPs in their casework.

Grounded Theory (Charmaz 2006) and thematic analysis (Howitt 2013 and Braun and Clarke (2008) were considered most closely as potential approaches.

"In some respects, thematic analysis is most similar to grounded theory, though it does not involve the same level of sophistication in data collection and theory building. However, properly done, thematic analysis has quite a lot in common with these other analytic methods" (Howitt, 2013, p177).

Howitt (2013) asserts that thematic analysis pre-dates grounded theory very substantially and is underpinned by a simple idea that complex qualitative data can be summarised effectively by identifying major themes that recur within a data corpus. I present the following reasons for selecting thematic analysis:

- This study is a small, localised and discrete study. It could be argued that my study could be seen as the start of a process of developing a Grounded Theory, rather than an end of a developed theory (Silverman, 2011, p71). I was not a full time or professional researcher immersed in a world of research, who was in a position to build a grounded theory over time through repeated sampling over multiple sites. Theoretical sampling helps develop grounded theories, based on situations and concepts which are progressively widened by including social situations very different from those with which one began (i.e. if my research were to be repeated in other contexts). Whilst social constructionist Grounded Theory methods of analysis could perhaps have been employed, the end-product of this study would have arguably been a grounded description, rather than a developed grounded theory: a criticism of many 'supposed' grounded theory studies (Charmaz 2006 p135).



- Much was already 'known' to me as the researcher about the literature on EP problem solving, autism, attachment and differential diagnosis. Whilst these knowledges could have been managed and accounted for as 'sensitising concepts' as described in grounded theory texts (Bowen 2006), the study could have been criticised as disingenuous.
- Thematic analysis, whilst criticised as being atheoretical, does have the flexibility to be aligned within constructionist or realist positions and uses a structured, systematic approach to data analysis similar in many ways to grounded theory (Braun and Clarke 2006).

Within my subject position as researcher, I believe that other EPs, as I, hold a fund of knowledge related to the fields of Autism and Attachment, and of the problem solving processes of our generic practice. I did not hold predetermined views about how EPs would respond in discussion in relation to the research area (apart from anticipating that EPs would benefit from more than one discussion). In this way, analysis was necessarily informed by our existing knowledge. Yet as the researcher, I wanted to remain open to discussion and open during analysis of the 'content' of EPs' accounts, as noted in section 5.2.6. The interview talk was structured to some degree by open questions directing talk to particular broad areas. Analysis of responses therefore contained a deductive element. Analysis was also inductive, both during interview conversation and during analysis of interview transcripts. This inductive analysis identified significant themes of talk that were not directly targeted through the planned questions. Braun and Clarke (2006) describe the difference between deductive and inductive analysis,

"Themes or patterns within data can be identified in one of two primary ways in thematic analysis: in an inductive 'bottom up' way or in a theoretical or deductive 'top down' way. An inductive approach means the themes identified are strongly linked to the data themselves...the themes identified may bear little relation to the specific questions that were asked of participants... Inductive analysis is therefore a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher's analytic preconceptions. In this sense, this form of thematic analysis is data-driven...In contrast a 'theoretical' thematic analysis would tend to be driven by the researcher's theoretical or analytical interest in the area, and is thus more explicitly analyst driven" (p83-84).

Howitt (2013) states that the history of thematic analysis goes back to the 1950s, “first appearing in psychological journals in 1943” (p 180) and that the development of quantitative content analysis and subsequent call for qualitative content analysis has much in common with it (p175). Howitt suggests that thematic analysis could be seen to occupy a middle ground between quantitative and qualitative analysis. According to Howitt (2013), one could suggest that qualitative content analysis and thematic analysis are pretty much the same thing (p181); “a searching-out of underlying themes in the material being analysed” (Bryman, 2004, p392, cited by Howitt, 2013). Vaismoradi et al (2013) conclude similarly, suggesting that a main difference appears to be in the opportunity to quantify data in content analysis. Howitt (2013) reports that thematic analysis:

- is a descriptive method, rather than a theory-building approach;
- is primarily aimed at describing the broad features of data (rather than providing a detailed interpretation of the data) and can serve its purpose by simply describing what is going on in data;
- tends to generate findings which are readily understood by outsider groups;
- is an analysis of what is said, rather than how it is said;
- consists of broad categories or themes describing significant features of the data, which are then woven together with quotes or excerpts to illustrate analytic claims (p176 and 177);
- provides a way of organising and analysing data (although I would argue that analysis is possible through the organisation of data, or that analysis and organisation are simultaneous);
- is good when there is evidence of extensive and systematic engagement with the data; and
- is high on intellectual demand when done well.

Howitt and Cramer (2011) schematically represent thematic analysis as comprising three phases, which can overlap considerably; obtaining and transcribing textual data, analysis, and identification of themes / sub themes. The analytic method employed within the current study is congruent with

the overarching steps outlined by Howitt and Cramer summarised in Table 10. The section on procedural design will provide a more detailed account of the method.

Table 10. Formal analytic steps followed in the current study, shown alongside Howitt and Cramer's (2011) 3-step conceptualisation.

Howitt and Cramer	Current study
Obtaining data and transcribing them	Engagement with the data through transcription correction and annotation. Mostly organising data, some analysis
<p>Analytic effort – the process of how themes came to be i.e. the work the researcher does on / with the text to generate themes</p> <ol style="list-style-type: none"> <li>1) Familiarise with the data</li> <li>2) Codings or conceptualisations applied line by line or by topic of talk</li> <li>3) Researcher processing/ re-processing to ensure analysis fits the data</li> <li>4) Researcher effort in resolving difficulties encountered during analysis</li> <li>5) Frequency and thoroughness of checks between the analysis of the data and the data</li> </ol>	<p>Reading and listening for topics of talk (themes)  Note taking in margins against topics of talk  Lifting / extracting the topics of talk with quotes / line numbers into a thematic map  Grouping or clustering topics of talk (with their quotes attached) for each individual  Repeating and then synthesising topics of talk identified during subsequent interviews for the same individual  Synthesis of topics of talk across volunteers into an overarching cohort matrix to help identify further formal analysis</p>
Identifying themes and subthemes	<p>Working on the overarching matrix to select topics for further examination and re-state research questions  Scouring thematic maps again with the identified research questions in mind across all volunteers to inform a cumulative grid  Repeat for all identified research questions  Combined data set – a constructed account of practice in relation to 4 identified research questions</p>

This approach enabled the familiarisation with, and systematic organisation of data, whilst engaging in deductive analysis (specifically looking out for identified material) yet remaining open to exploring, inductively, what else volunteers wanted to offer.

“Like all aspects of qualitative data analysis, it is practically impossible to completely separate coding (note taking) phases from the theme generation phase. There is an interplay, which no description of the process can capture” (Howitt, 2013 p186).

In summarising key points about thematic analysis, Howitt (2013) uses a range of emotive words to sum it up as a technique: ‘intense, detailed, hard work, devoting intense effort’ on behalf of

researchers in producing convincing analyses. This choice of wording reflects both the systematic yet subjective nature of the analytic process.

Thematic analysis applied to 'data' collected in a 'one off interview' would arguably offer a more static approach to analysis, which would deny some of the possibility and opportunity for the change, growth and development of an account over time, aspects considered desirable in the current study.

#### 5.4.1 The end- product of interviews – putting stories to honest and intelligent use

Silverman (2011) suggests that all data are to some extent an “artefact of how they are collected”, there are fundamental limits to what can be known about a phenomenon under examination and therefore that ‘good’ research methods are those which best address particular research questions (Silverman 2011, p15). Aligned with the constructionist position that, “interviews are collaboratively produced” by both interviewer and interviewee, and that therefore, ‘with other questions, at another time, other truths or stories would have emerged’ versions of events are seen as having at best an indirect relationship with behaviour outside of the interview context.

From a social constructionist viewpoint that no story can encapsulate all of lived experience, the stories EPs choose to talk about indicate what experience or aspect of experience they give more meaning to, and so is valid to them. Gubrium and Holstein’s (1997) account of the active interview, contends that volunteers cannot ‘misrepresent their own accounts’,

“Construed as active, the subject behind the respondent not only holds facts and details of experience, but, in the very process of offering them up for response, constructively adds to, takes away from, and transforms the facts and details. The respondent can hardly ‘spoil’ what he or she is, in effect, subjectively creating (1997b, p117 cited Silverman 2011, p182).

Kitzinger (2004) similarly expresses interview content as a form of talk about an experience,

“ constructionism...treats as inappropriate any attempt to vet what people say for its ‘accuracy’, ‘reliability’, or ‘validity’ – thereby sidestepping altogether the positivist problems of uncovering ‘facts’, ‘realities’ or ‘truths’ behind talk” (Kitzinger, 2004, p128 cited Silverman 2011, p181).

Miller and Glassner (2004, cited Silverman, 2011, p190) talk about the utility of research in the form of accounts or stories,

“All we sociologists have are stories. Some come from other people, some from us, some from our interactions with others. What matters is to understand how we can put them to honest and intelligent use in theorising about social life” (Miller and Glassner, 2004, p138).

In the current study, well-kept documented procedural records of how accounts came to be, will demonstrate ‘reliability’ (Silverman 2011).

A detailed description of the procedural aspects of the method is provided in the next chapter.

## CHAPTER 6

### RESEARCH DESIGN AND PROCEDURES – METHODS OF DATA COLLECTION AND ANALYSIS

This chapter provides a detailed description of the procedural aspects of the research design.

#### 6.1 Pilot phases

Use of the word 'pilot' evokes connotations of positivism: suggestive of a discrete phase that happened 'before and separate from' the 'real' interviews and used to iron out snags before a polished, uniform tool is finalised. It would be truer to speak of those early encounters as part of a process of development and adaptation within the research process (Darlaston-Jones 2007). The research process was dynamic in that it was:

- developed through dialogue with volunteers and critical reflection on their feedback;
- responsive to individual needs and preferences; and
- sometimes turned on its head by unforeseen circumstances. The 'pitfalls' of real world research (Easton et al 2000) meant significant adaptation was required which included:
  - squeezing interviews in working hours;
  - the quality / suitability of rooms available on work premises;
  - volunteer cancellations (due to illness, family commitments);
  - researcher cancellations (family illness, audio equipment failure);
  - difficulties timetabling and protecting mutually convenient sessions of sufficient length; and
  - unreliability of the transcription service meeting timescales.

Two former colleagues were approached to support the study by piloting (i.e. being the first to try) various aspects of the research design. First, the oral briefing form (Appendix A), and consent forms (Appendix B) were both trialled, and colleagues' oral feedback considered in redrafting. Secondly, proposed interview questions and structure (Appendices D and F) were trialled. Feedback was solicited in a more structured, yet dialogic manner, using a brief series of planned open-ended questions (Appendices E and G).

Appraisal of their combined feedback at early stages of the research processes had implications for:

- refining the oral briefing, consent form and interview structure;
- refining the means of preparing other volunteers for the initial interview; and
- designing the means of facilitating discussion during interviews.

Key aspects that I reflected upon during those pilot phases were:

- the stake – what was at stake for me as researcher and colleague and for the colleagues taking part;
- power relations – the different nature of the relationships that existed between me and individual volunteers; and
- facilitating talk – how to sequence and structure guiding questions to best effect in addressing the research questions and enabling constructionist dialogue during the interview.

Critical reflection on the feedback provided during pilot activities fundamentally transformed my appreciation of the role and importance of the oral briefing. I moved from viewing the oral briefing as a necessary step in alerting colleagues to the opportunity take part in the research and the consent form as a mere formality in ‘signing up’, to being integral first steps in managing identities, starting a research relationship and the possible trajectories of interview talk. However, reflections during the pilot phase led me to consider the briefing anew as an important part of establishing contact with volunteers, and explaining what they might expect by taking part. The consent form subsequently came to function as a sister document to the briefing. It adopted a more formal tone and addressed in detail the contractual elements of taking part. The content was informed by the specifics of this research context, namely that research was being undertaken between professional colleagues who would have an ongoing relationship outside of, and after the research had ended. The professional standing and level of qualification of those engaging in the research also informed the level of description included in oral explanation and in writing. Critical appraisal of pilot feedback also fundamentally transformed the opening stages of the interview. Changes were made to:

provide a more explicit dovetail with the oral briefing and consent stages; pay explicit attention to power dynamics and identities; and check for shared understanding of my intended active role within the interview in facilitating process of and in the co-construction of accounts.

Thirdly, I was able to try different approaches to second interviews. An interview guide supported the process of first interviews (Appendix H) but a method of approaching subsequent interviews was needed. For one volunteer, I sent her a transcription of her first interview including my notes of things I was interested to clarify at a further interview. Her feedback was that although she did value having a copy of the transcript to 'glance over'; knowledge of my ideas ahead of a second interview was not helpful. To the second volunteer, I sent simply the transcript. She chose not to use this ahead of our second interview. These two volunteers had different process preferences. Understanding this informed my decision-making about how I could respond to the individual needs of other volunteers. Transcripts were to be offered to volunteers who could then refer to these, or not, as they preferred.

At the pilot stages of planning and trialling different approaches to second interviews, I listened to the audio recordings and typed up volunteers' responses against the questions asked. This activity of closely engaging with the audio recordings to produce a form of text enabled me to develop an appreciation of:

- the complexities and time- consuming nature of full verbatim transcription;
- the complexity of interaction; and
- the time resources that might be required for data analysis.

The process of that activity also helped me develop my understanding of what 'data analysis' really meant in the context of the current study e.g. to what extent data analysis could be considered only



to take place in a particular designated phase 'post -data collection', or whether analysis might be better understood as occurring throughout the research process.

## 6.2 Recruitment to the study

In line with the values implicit in a constructionist methodology, which adopted an active approach to interview and an iterative approach to analysis, I refer to those who took part in the study as volunteers<sup>7</sup>.

I recruited volunteers opportunistically, harnessing relationships developed within a local authority where I had previously worked, and seeking involvement from colleagues where I worked at the time of data collection. This was a pragmatic decision. EP colleagues were readily accessible, as they lived and worked locally; were considered more likely to engage with the research (since they knew me and I anticipated would trust me as the researcher); and were thought more likely to continue their engagement throughout the study (through both familiarity and proximity). Appendix C provides summary information about the professional post qualification experience of all of the volunteers, the casework examples drawn on in their interviews and other details pertaining to their involvement in the study. This information was not directly solicited as part of the recruitment process. It is provided for methodological comparison with the existing work of Moran (2010, 2015) and with future studies. The information provided in Appendix C indicates that volunteers had varied experiences that might be expected of a locally focused opportunistic approach to recruitment. They were not therefore an 'expert' group selected or targeted using a predefined profile of autism and attachment related experience, a feature discussed in the conclusions chapter. Five of the six volunteers, however, had had experience of contributing to local multi-agency diagnostic assessments for autism, and one had taken a lead role at clinic based diagnostic discussions.

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<sup>7</sup> The reader will notice that the briefing and consent forms refer to participants. The word volunteer was decided after discomfort with the positivist flavour conveyed by the word 'participants'.

Preliminary questioning suggested that the number of willing EP colleagues was between four and five. Ultimately, eight volunteers consented to participate, six from my work place and the two from my previous work place whom I had approached for development of the research design. Volunteers were allocated numbers 1-8 as identifiers. Unforeseeable changes in circumstances of two volunteers meant that they became unable to continue. Therefore, the final number of volunteers actively engaged in the current study was six, although their numeric identifiers remained unchanged for the purpose of clarity<sup>8</sup>. With at least two interviews anticipated for each volunteer, this sample size was considered to provide sufficient material for the identification of patterns across data within the remit of the research (Morse 2000) and the suggested number of interviews “10-20 for a medium TA project (e.g. UK or NZ Masters; UK Professional Doctorate”) (University of Auckland 2013).

All potential contributors were briefed orally using prepared notes, so that they each received the same information about the study, and were able equitably to appraise the opportunity to engage (see Appendix A for oral briefing notes). There was scope in the oral briefing to deviate from the notes to enable clarification on any issue. For those interested and willing to engage in the study, a consent form (Appendix B) was discussed, signed and a copy kept by both parties. An additional purpose of the oral briefing and consent phases was an explicit check that volunteering colleagues had indeed experienced a situation of the type to be discussed during the research process and therefore had relevant experience on which to draw.

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<sup>8</sup> Of Eight EPs who volunteered, six took part but numeric identifiers were retained as originally allocated. This explains why the findings chapter talks of ‘volunteer number 7 and 8’.

### 6.3 Initial interview procedure

A number of sources informed the design of the interview guide for initial interviews, as detailed in Section 5.2.6.

I interviewed each volunteer individually. Interviews were audio-recorded using digital equipment. A copy of planned interview questions is provided (Appendix H) for transparency, but the reader is reminded that although the questions are presented sequentially within the matrix, each interview developed and evolved its own course, one that is not necessarily reflected by the order or content shown. Some planned questions may not have been used at all, and questions were asked that were not planned. The interview questions prepared, therefore, served as a guide or aide memoire to facilitate management of the interview process. The first interview ended by setting a date and venue for a subsequent interview.

I made field notes during the interviews. This was largely to help me process the detail of what we discussed, and at times, note things of interest, such as turns of phrase, or where choice of words were striking. Audio recordings were replayed as soon as practicable. Following this, audio recordings were saved with their numeric identifier to the University of Birmingham secure network computer system and uploaded via a secure site to a professional transcription service based within the region. The field notes were stored securely along with a data management sheet (Appendix I), so that I could later connect the notes with the corresponding transcript.

### 6.4 Transcription

The transcription service produced a Word document of all interviews, using a pre-set layout. The pre-set lay out for verbatim transcriptions followed a standard:

- Margin size
- Header (date of interview and volunteer number)
- Page numbers

- Line numbers
- Font
- Font size
- Interview and interviewee indicated on different lines

This initial transcription was considered a draft. I listened to the audio recordings for the purposes of checking for accuracy of verbatim aspects of transcription and making necessary amendments. I then added annotations (described in Section 5.3.1) to capture aspects of speech that were not graphically represented by the verbatim transcription. The annotated transcriptions were stored electronically along with their corresponding data management cover sheets as Word documents.

### 6.5 Subsequent Interviews

A copy of the transcription of their initial interview was given to each volunteer, as soon as available. Volunteers chose whether to engage with their transcripts ahead of subsequent interview sessions.

My preparation for a subsequent interview, as interviewer, was to re-read the transcripts and annotate where I would like to direct talk, or seek clarification at the next interview. The aim of this was to ensure I achieved as secure an understanding as possible. A further aim of subsequent interviews was to continue the construction of an account of individual practice, towards a point of satisfaction of fullness of account on behalf of the volunteers. This preparation formed a loose agenda for subsequent audio-recorded interviews. It was the case that no volunteers had suggestions of things they would like to focus on in subsequent interview discussion. Those subsequent interviews were transcribed, stored and circulated using the same procedures as initial interviews. Five of the six volunteers were satisfied in their accounting after two interviews. One colleague had three interviews before reaching a point of fullness.

Thirteen interviews took place in all. The volume of combined data approached 15 hours of audio-recorded interview or nearly 400 pages of transcript. Appendix J provides information about the number and length of individual interviews.

## 6.6 Data analysis

The intention of this section is to describe the analytic processes followed within the current study, where data analysis was multifaceted. It occurred:

- throughout the interview discussions in the form of the active participation of me as researcher and volunteer;
- in between interviews on behalf of both myself as researcher and volunteers; and
- once the interviews were concluded in the form of thematic analysis of interview transcripts.

This section cannot account for the private process of individual volunteers, but does address my analytic process as researcher. I suggest in Table 11 a number of junctures of where analysis was active.

Table 11. Points of active analysis

Step	Activity	Purpose / end
Step 1	during interview	my analysis took the form of following and trying to understand what volunteers were expressing and making connections with what I thought, with what others had said, and with what I had read
Step 2	replaying audios and reading field notes	getting a sense of the content and shape of the discussion outside of the immediacy of the interaction
Step 3	checking transcripts	for accuracy and amending
Step 4	annotating transcripts	so that they conveyed more of a sense of the interaction and the manner in which things were said (3 and 4 affording familiarity with the data content and interactions that produced the content)
Step 5	noting questions in the margins against sections of talk	where I wanted to seek further discussion or clarification about what had been expressed
Step 6	during subsequent interviews	using the prepared notes / prompts to check out my understanding of the account under construction.
Step 7	during note taking and theme generation	<p>using topics of talk (in transcripts) as units to be coded, the transferring of notes into a thematic map, where notes of similar topics were clustered together. Elements of talk that I interpreted as being on the same topic (regardless of actual content / agreement / deviation as to opinion or perspective) e.g. talk about genetics and jabs were grouped under aetiology of autism. Sorting / grouping based on similarity is how Howitt refers to moving from codes to themes to tentatively display relationships between themes.</p> <p>“Like all aspects of qualitative data analysis, it is practically impossible to completely separate coding (note taking) phases from the theme generation phase. There is an interplay which no description of the process can capture” (Howitt, 2013 p186)</p>
Step 8	combining thematic maps	evidence of a topic across all interviews for an individual were synthesised
Step 9	comparing and contrasting thematic maps	cross case analysis, using a cohort mapping matrix (Appendix J) to justify analytic choices
Step 10	re visiting entire data set with new research questions	re-organising data with new research questions as organisers
Step 11	consideration of the re-organised data set	in order to present (describe) and interpret the new data set.

Whilst steps 1-6 in particular appear sequential and as if self-contained within the handling of an individual volunteer's data, engagement with the cumulating data offered by a number of volunteers did influence my interpretation of subsequent interviews.

At the end of the second interview, volunteers were asked whether a further interview would be helpful / welcome, or whether their account was 'reaching fullness'. At the point of expressed 'fullness' the individual interview data sets, in the form of transcripts, were analysed thematically (analytic steps 7-11), in Table 11.

Howitt (2013) proposes that good practice in thematic analytic studies should include some detail of the analytic process. Table 11 provided a summary of points of analysis. The following sections detail the series of steps of thematic analysis as applied to the current study, which as signposted in the previous chapter (Table 10, section 5.3.3) followed the analytic steps described by Howitt and Cramer (2011). This description begins with step 7 from Table 11.

Step 7a I read the transcript from a volunteer's first interview and made notes in the margin against sections of talk where I interpreted a topic was expressed. Notes took a summary form, giving an indication of the nature of the topic that I readily understood. Sometimes a section of talk expressed two or more topics. All topics identified were noted.

Step 7b Those notes, handwritten directly onto transcripts, were transferred to (typed into) a landscape-oriented Word document, called a thematic mapping. Each Word document adopted the same formatted layout, with headers and footers, page numbers and content arranged into a grid. This standard approach to presenting data allowed ease of comparison at later stages of analysis, where volunteers' accounts were compared and contrasted. Line numbers from the transcripts were retained to ensure an audit trail back to the original source. Quotations were recorded alongside,

where I judged these helped illustrate a point, but were not used so extensively that effectively the entire transcript was imported or simply re-shuffled. An illustrative example from one of the thematic mappings documents is given next (Box 5). The green text indicates that this was taken from a third interview (in this example, Volunteer 1, Interview 3, beginning at line 32).

Box 5. Extract from the thematic map of Volunteer 1.

Beginning at line number	Quote	Synopsis content	Theme
32	I think, as a practicing <i>EP</i> , you've got in your head certain things that are, I don't want to use the word <i>red flag</i> , but are things that you [pause] find your ears <i>prick up at</i> a little bit <i>more</i> than they would do for maybe something else Right or for <i>somebody else</i>	EPs have knowledge that perhaps other professionals don't have	<b>EP identity</b> versus other professionals

Step 8 was a repeat of steps 7a and 7b focusing on that volunteer's subsequent interview transcripts, and again, the notes handwritten on the transcripts were added to the thematic map that contained data from the first interview, in a way that enabled topics to be grouped or clustered. I used different coloured fonts to indicate whether topics and their notes had come from first, second or third interviews (for audit trail purposes). Taking this same volunteer, Volunteer 1, as an example, black indicated the topic was taken from the first interview, red from a second, and green from a third (Box 6).



Box 6. Extract from the combined thematic map for Volunteer 1 illustrating how talk from across three interviews was synthesised.

Beginning at line number	Quote	Synopsis content	Theme
32	I think, as a practicing <i>EP</i> , you've got in your head certain things that are, I don't want to use the word <i>red flag</i> , but are things that you [pause] find your ears <i>prick up</i> at a little bit <i>more</i> than they would do for maybe something else Right or for <i>somebody else</i>	EPs have knowledge that perhaps other professionals don't have	<b>EP identity</b> versus other professionals
213		EPs – think psychologically, about a whole child, that perhaps others don't focus on	<b>EP identity</b> versus other professionals
767		CAMHS clinicians don't have the knowledge and skills or understanding to undertake assessments in schools / educational settings. EPs as uniquely placed / skilled to get education based information (and interpret it / make meaning from it – psychologically)	<b>EP identity</b> versus other professionals

This activity led to the construction of a combined thematic map of topics of talk across an individual volunteer's entire talk time.

Steps 7 and 8 were repeated for all volunteers, thereby producing a thematic map representing topics of talk for each volunteer.

Step 9 was to compare and contrast all of the thematic maps with each other. This decision making process about which aspects of the data could be legitimately focused on for the purposes of the current study was facilitated by constructing a cross-cohort thematic mapping matrix (Appendix K). This onward analytic decision-making was not solely informed by the gross overview of the data provided in the cross cohort-mapping matrix but also by:

- my critical re-consideration of the original research questions now that they were so richly contextualised by the broader topics that were constructed over the course of interviews; and

- my “feel” for the data, gained through the multi-faceted engagement with the research over time.

Step 10 involved re-visiting all the talk of all volunteers that spoke to those selected four research questions. This was achieved through a number of steps. Firstly, I re-visited the thematic map of each volunteer with one specific research question in mind. All talk pertaining to that particular research question (however originally grouped / themed) was transferred into an overarching ‘cumulative map’ dedicated to that particular research question. I repeated this step for all of the other volunteers’ talk focusing on the same research question. Four separate cumulative grids were therefore ultimately constructed, one for each of the four research questions. These cumulative grids captured the identified talk from all of the volunteers on specific research questions (Appendices L-O).

I identified two strands within one of the research questions (number 3), problem analysis activity and the nature of the overlapping phenomenology, so talk pertaining to that research question, was presented in a cumulative grid and also subsequently woven into the Coventry Grid (version 2) (Moran 2015).

This re-mapping and grouping exercise involved ongoing analysis in the form of active engagement with interview talk.

Step 11 was the analysis of the re-organised talk in order to construct, present (describe) and interpret perspectives on practice for this particular group of volunteers.

Steps 1-9 indicate the analysis of talk that was undertaken in addressing my original research questions. However, the originally planned questions of ‘How do EPs conceptualise autism and attachment?’ and ‘How do EPs conceptualise their problem analysis processes?’ instead became

much richer and / or contextually grounded when considered in the context of other aspects EPs chose to talk about:

- 1 How do EPs conceptualise autism and attachment?
- 2 How do EPs conceptualise the value of discerning autism from the enduring effects of early attachment experiences?
- 3a How do EPs conceptualise the overlapping phenomenology? (In making statements like this, "It looks more like attachment" in the context of a possibility of ASD, what do EPs mean?)
- 3b How do EPs conceptualise their problem analysis processes? (What do EPs do when they encounter the possibility of interpreting behaviour either as an ASD or as a suggestive of attachment related themes?)
- 4 How do EPs conceptualise the distinctiveness of their contribution to problem analysis in this particular area?

According to Braun and Clarke (2006), 'unanticipated insights' are possible within thematic analysis. Similarly, Howitt (2013) states that reformulation of research questions during the process of analysis is not unexpected (p188), although he does suggest this is only likely if the procedures are centred on the data and when a researcher revises their analysis in light of the data (p190) as was the case here.

## **CHAPTER 7 FINDINGS**

### 7.1 Introduction to findings

This chapter both presents and discusses the selected topics of talk constructed during iterative individual interview processes with six volunteer EPs. It was necessary to make analytic choices due to the significant volume of material produced; data comprising nearly fifteen hours of audio and almost four hundred pages of transcript. The interview process was designed and conducted in ways which allowed volunteer led talk and I had remained open to hearing other topics of talk that they had wanted to bring. This approach subsequently generated such 'richness' that it was not possible to manage all responses within the analysis of the current study. The decision making process was described under Step 9 in the previous chapter.

These other dimensions, considered somewhat peripheral to the current research purpose will be outlined first as background dimensions and then set aside, with the suggestion that they could be subject to more focused analysis elsewhere. Discussion will then move on to the four primary foci for analysis.

A number of features that would be interesting to consider relate to the specific nature of the research methodology employed. Firstly, this process involved conducting research as a practitioner with colleagues in the region. Similarly, the volunteers, as research participants, are practitioners in the field of enquiry. This context is in contrast to that which is often the case in research where the professional researcher is an outsider who may be unfamiliar with the contexts and habitats of the volunteers. Of practitioner –researcher enquiry, Winter writes,

“Experienced practitioners approach their work with a vast and complex array of concepts, theoretical models, provisional explanations, typical scenarios, anticipation of likely outcomes, etc... A ‘research’ process must demonstrably offer something over and above this pre-existing level of understanding” (Winter 1989, p 34-37, cited by Robson 2002, p536).

Allied with this, it would be interesting to consider the ways in which the researcher experience of undertaking this methodology resonates with the daily practice in the role of an EP. Parker (2013) argues that “there are strong parallels between effective research practice and appropriate professional applied practice” (p84). There are some obvious parallels in this study, from ethical considerations, eliciting views, recording, reporting and sense making. An additional perspective on the methodology would be to consider the ways in which the iterative interview process (with recording and transcription) offered a model of supervision. Engaging in the research process functioned as a learning conversation, with active reflection being something commented upon by a number of volunteers during the process.

A discursive analysis of the language and terminology used by volunteers could explore implicit ideologies. For example, one volunteer spoke of parents ‘banging on’ [until they get what they want from professionals] and others spoke of ‘labels’ and ‘diagnoses’ somewhat interchangeably. Labels were referred to as ‘tickets to open doors’, and doors were spoken of as ‘swinging open’ as a result of diagnoses. Aspects of the conduct of other professionals whom they had encountered dissatisfied some volunteers EPs who spoke about them ‘latching on’ or ‘being blinkered’.

With regard to reflexivity, it would be worthwhile to systematically examine the transcripts in respect of my behaviour as researcher given my aspiration of approaching interviews as a process of egalitarian construction.

The analysis could have explored talk about the nature of the role of EPs, a topic that was perhaps predictable in hindsight, and has been subject to much reflection in the wider professional literature over a number of years.

The data in this thesis, therefore, could be used to tell many stories about EP practice. I judged that two topics of talk common across the group of volunteers formed a broader story around the 'stem' provided by the two original research questions and offered a logical, professionally relevant and conceptually coherent focus for analysis. Questions one and three were the planned research questions and were directly probed and therefore considered deductive in terms of analysis. Questions two and four were those identified through inductive analysis to offer a direct complementary significance to the planned research questions. The following sections of this findings chapter takes each of these research questions in turn.

In presenting my selected topics of talk, I acknowledge 'processing biases' or 'value interias' and my role as a 'go between' for the volunteers in this study and the audience of this thesis (Sadler, 1981). Interview extracts used in this chapter are to "serve as illustrations of a point" (Denscombe 2007, p200), are provided verbatim and identified through their volunteer number assigned in this study. As far as is practicable within the confines of this thesis, an indication of the context of the extract is provided by use of 'beginning at line...' thereby keeping extracts embedded (Denscombe 2007). Other complementary forms of data representation include the use of figures, tables and an adapted version of the Coventry Grid Version 2 (2015). I judged that those alternatives modes of representation enabled me, at times, to remain closer to the data (what people said) and provide greater clarity about my process of meaning making.

## 7.2 Research question 1. How do EPs conceptualise autism and attachment?

The cumulative conceptualisations of autism and attachment data are provided in Appendix L.

Table 12 provides a summary of main points from discussion of EPs' conceptualisations.

Table 12 A summary of EP conceptualisations of autism and attachment

<b>Autism</b>	<b>Attachment</b>
Problems of social communication and interaction due to the way the brain sees and organises the world	Difficulties with emotional and behavioural control which is in essence relational and emotional
Organic /biological causes Genetics brain structure Neurological components Pregnancy factors and jabs A biopsychosocial model Genetic propensity having large part to play Some smaller effects of upbringing	Environmental / social causes Significant separation in the early years for various reasons Lack of feeling safe with caregivers for various reasons which compromised 'availability' Prerequisites to be social but environmental factors compromise / disrupt the development of these capacities Some smaller genetic contribution

Discussion about conceptualisations of autism and attachment led more readily with most volunteers to talk of 'where it comes from / what causes it' (shown in the Appendix L as 'aetiology'), as opposed to discussion about 'what it is' in terms of how it manifests (shown in Appendix L as 'definition' and 'theoretical'). There was some agreement amongst EPs' conceptualisations of autism as a condition of a largely biological / organic origin with the expressions of genes or neurology interfacing with environment (even if the exact nature of environmental contributions and genetic certainties are not clearly articulated). This summary position reflects the current literature base presented in the literature review chapter which has not come to specific conclusions about genetics components and environmental contributions. Similarly, there was some concordance that difficulties relating to attachment are more to do with life circumstances, events and early interactions, with only one volunteer suggesting a smaller genetic component (Volunteer 2) and another referring to the child's 'temperament' (Volunteer 3) as a minor contributing factor. This

again has some correspondence with the literature base for attachment, which has focused on relational causes rather than individual child characteristics which may play a contributing factor to the development of attachment difficulties.

Volunteers 1, 2, and 8 spoke of how autism manifests, for example by referring to the three core areas of social communication, interaction and imagination. There was a relative absence of talk (only one volunteer, Volunteer 1) around how attachment manifests i.e. what it looks like (difficulties with emotional and behavioural control). Given the highly individualistic nature of each of the discussions, and the constructionist lens of analysis it is not possible to claim what this represents. The question could be posed though, “Although they did not in this study, are EPs able to talk, with the same confidence, as to how attachment difficulties presents?” This absence of talk about how attachment presents is interesting given that research has proposed that around 40% of the population are thought to have an insecure attachment pattern (Minnis 2006) with suggested implications for adaptive functioning and that ‘Social and Emotional Mental Health’ is one of the larger categories of Special Educational Need identified in LA 1 and 2 where the volunteers worked.

Both autism and attachment were presented to some degree in the form of deficit rather than difference (‘problems of’ / ‘difficulties with’, ‘lacking’, ‘futile’, ‘lack’) across Volunteers 2, 3, and 8.

There was a notable amount of talk from one volunteer (Volunteer 8) about how her unique subject perspective (years of service, changes witnessed in practice and diagnostic processes over time) has allowed her to come to her current thinking about both autism and attachment and how her work activity has likely shaped her understanding beyond her initial training. Volunteer 8 was the volunteer who talked most extensively about her knowledge base (how she conceptualises autism and attachment), which is an interesting observation as elsewhere in discussion she positions herself at a distance from theory (feeling she is ‘outdated’ and not cutting edge) and expressed feeling as



though her ideas (about overlapping phenomenology, addressed in research question 3) were [nothing more than] “conjecture”. Similarly, Volunteer 5, whose practice appears ostensibly very differently as expressed in these conversations, described the influence of personal experience (prior to EP training) on her work practice.

Behind the broad headlines of agreement, there were some points of divergence. Volunteer 5 did not discuss her conceptualisations of autism or insecure attachment. Her reasons for the absence of talk on this topic were solicited directly for transparency with regard to being able to represent her position on a planned research question. She expressed that she did not want or need to include such conceptualisations in her talk because she felt they were not relevant to how she practices, seeing them as red-herrings to the purpose of her work (Volunteer 5, beginning at line 229, and picked up again at line 786 of Interview 1 and again in Interview 2).

**Line 229: significant challenge, and within the school context their needs are *very difficult* to [pause] work with. And my more recent mantra, that I use to explain my role to the people, the adults with whom I'm working, is that I say to them, that my job is to *better understand what is going on here*. So, often, that is my remit. I am there to *understand* what's going on for a young person whose presenting with very significant needs within a particular school context, that's often Hmm what I'm tasked with. And within those *discussions, fairly regularly*, a question around *possible* autistic spectrum disorder is raised [pause] by somebody. Either that issue has been raised with parents, parents have Googled it and questioned it themselves Right it's *often around*, [pause] and my response or my, within my approach to my general work, what I'm very keen to do is *not latch onto any* [pause] *quick explanation* for what's going on for the young person, I'm very keen to build a much broader picture from which we can better understand what's going on for them. So, whilst ASD might be *mentioned*, I would not want to be *blinkered by such a diagnosis*, potential diagnosis, because I think that if we jump too quickly onto such a diagnosis that could mean that we ignore significant pieces of information around the child's experiences. [pause] *However*, what I *tend to do* fairly often is, without the *need for* an absolute diagnosis that's backed by, you know, masses of assessment information, loads of reports, Hmm “multi-agency agreement, what I *often will do* is use a *framework***

*for intervention* which relates to the broadest spectrum of young people with social communication difficulties, *to help the child* within the context within which they're working. So I often take not a great deal of notice of whether or not they've *got* a diagnosis, whether or not they might *get* a diagnosis, the diagnosis bit is not important, *often, to me*, because I'm much more, I *think*, pragmatic about, well, what can we do to help this young person in the widest sense, you know, with the broad spectrum of needs that they're presenting with. If a bit more structure and planning of routine and regularity and organisation of information is helpful to them, then I would take that pragmatic approach to suggest that people might do those sorts of things to help them manage it, [pause] whilst *at the same time*, I've also got another *eye on* what's going on for them emotionally. *And*, so I guess this is the *other bit* of this discussion, around [pause] *what often* is needed for young people in such a level, degree of crisis, is that often we need to reduce stress levels and help them feel contained within themselves emotionally. So all of the *stuff* you might do in a more considered and structured way for a child who has got an official diagnosis, *actually*, it doesn't do any harm because even if it doesn't help them because they particularly need it, it's *likely* to help them organise their thoughts and manage their emotions better, so it doesn't do any *harm*. Okay. There's lots in there already, isn't there, [name].

786: [long pause] So the bit that, I think, perhaps I've *missed* in terms of thinking about some of those original discussions around the ASD attachment Yeah the *process* that we have *undertaken*, and I'm thinking about that year seven boy Yeah by way of example, because we don't know. Actually, by the time I've done all of that *work*, to be *perfectly honest*, I'm not, you know, whether or not he achieves or doesn't achieve a diagnosis is, to some extent, a little by the by. It's *helpful, to know*, if he gets one, and it's *helpful to see what the assessment has revealed*, but, actually, I'm so focussed on *my* [pause] *process*, that that feels quite separate, and I'm still wondering, and that position that I mentioned at the beginning, of our Yeah in the very first bit of our discussion where I'm saying, "Actually, I don't have a need to find the end to that", I don't *need* to know whether he's got an ASD diagnosis *or not, actually*, we'll still do this same piece of work.

Volunteer 5, Interview 2, beginning at line 697,

**Line 697: Yeah** [pause] your and how that fits with the purposes and nature of your role as you've described them, [pause] have I understood it right that, whether it's a *this* or whether it's a *that*, kind of doesn't enter into your activity because your activity is about, as we said in the beginning, [pause] I've lost where we're at, I've bullet pointed them, haven't I **Yeah** it's the narrative, producing the narrative that tells the story for the young person, erm it's to

think about the pragmatics, it's the actions that are going to come from it, it's about the understanding. **Yeah** So you've got that with an end in mind, if I had ideas that I would want to probe around your, well, how do you conceptualise autism, then, and how do you conceptualise attachment, shall we, are we parking that because that actually doesn't factor into your activity? **Yeah I think what I'm doing, and that's been a helpful reflection of our discussion because I've realised what I'm doing [laughs] when I'm taking a developmental history, what I am *actually mapping* is their *emotional developmental history*.** Right

Volunteer 7 expressed that she was aware of various positions / perspectives and research but that she had not made up her mind, her ideas were evolving and she was unsure of the utility of categories relating to attachment and autism. (Volunteer 7, beginning at line 449 and again at line 835 of Interview 2)

Line 449: You've used the word developmental erm in relation to him and his brother's behaviour, **Hmm** I wanted to check with you **Okay** whether I was using the word in the same way **Right** you were. So, when you were thinking about the possibility of autism spectrum, did you mean, when you used the word developmental, did you mean *the copying*, so it was a *learned behaviour*, or did you mean almost like, well, some people would say *genetic* contribution of, so when you've called it developmental, **Yeah** what does that mean? **Yeah, whether that would be the autism factor, I suppose, in terms of, is it a developmental disorder, if you want to use it in that way** Right or is it, **yeah. But, I suppose, alongside that is, yeah, who's modelled to him, other things as well, I suppose. But, yeah, I think when I said developmental, I think I meant in terms of the autism.** Is that how you, I know you talked about *people* talking about autism, is that how *you* would talk about autism, as a developmental disorder? **Erm?** I say talk about it, conceptualise it. **Yeah, I think I'm still probably quite [pause] unsure [laughs]** Oh right **about like whether, because there's loads of contradictory things, loads of research, and maybe I, yeah, I think in the past I have. I don't know whether I would talk to schools using that language, probably not. I don't know, yeah, it's interesting that it came out, and then [laughs] [unable to hear 32:10].** So would you have, what's your, is your current view *evolving*, then, still, about what [unable to hear 32:19]? **I think so, yeah, yeah, because about the genetic input, about, you know, is it something purely developmental, is it, you know, neurological, what is going, what's...Has something *happened*, then, from, *over time* that you maybe thought it was this and now you're not quite so...I guess, when you first do your psychology degrees and they talk about it in that way** Hmm well, that's sort of how I was kind of initially taught it, and then

as you come, as you've read more things Yeah or read wider, that you realise it's not this one view of it and there's lots of different Right aspects. I mean, *I'm* probably not up to date in terms of reading about autism either, and there could be lots of other theories [laughs] I don't know about, erm it's not my area of expertise Hmm as such. But, yeah, I don't think I have a *clear idea* in terms of *what it is*, I mean, Right how it presents, but, I suppose, in terms of underlying causes or...

Line 835: But, I suppose, just before we go today, did you have a view at this point about [pause] where you think you've got to in terms of *talking to your*, that situation that you've chosen to talk about, and do you want another session or do you think you've about nailed it? Yeah, I think I just need to make time to, more read through the transcript, and I think that will be helpful for me Yeah to think through that a bit more. Erm I don't think, yeah, I think I'm still making sense of the ASD attachment and I'm thinking what the purposes of having those categories, I suppose, and are they, when are they helpful or not helpful or, you know, how do we use them, like you say. Hmm It's interesting unpicking my idea of autism, I suppose, I hadn't really thought about it for a while [laughs].

Whilst Volunteer 7 was unsure of her view about conceptualisations, Volunteer 8 spoke of being aware of 'accepted positions' but not necessarily agreeing with them herself and instead was able to state her own view, including expressing some disquiet about the 'accepted' position of attachment research, evidencing her critical, reflective practice.

Volunteer 8 (beginning at line 1052 and again at line 1102 in Interview 2)

Line 1052: *I'm not on the diagnostic team, [pause] the only time, like I say, what's provoked me to think about it, the only time I can, you know, anticipate, would be kind of in training, and I'm really quite uncomfortable about the attachment training because of the the er the kind of categorisations that are going on, that I really worry what sense inexperienced people make of that, who don't have a lot of experience of kids, is that In terms of attachment? Yeah, just just people looking for things, "Oh, attachment", you know, they're going to go around being the attachment difficulty police type thing, er that they bother me. [laughs] [pause] And, again, I'm not entirely sure, yeah, I've got lots of qualms about attachment in general, really. Hmm. You mentioned steering away from it. Yeah, it's the forty, it's the bit about, which bit about forty percent isn't normal and it's blinking, I just really worry about erm it being that blooming Strange whatsit situation. It*

seems *such a bizarre one, anyway*, it's so much, you know, seems to...So the strange situation test was bizarre? It's a bit like Do you mean? Yeah, I kind of think for like the Margaret Donaldson's stuff and what have you is, erm in the, and the Piagetian stuff, is like what seemed like really, ooh!, cutting edge in the seventies, when you look back and, you know, those bits, I don't know if we talked about that the other day [laughs] Yeah it was like, when I want people to ask a different question [laughs] kids just kind of come up with something. Now, *I know there*, the kids weren't being *directly challenged*, but they *were in a lab*, which *would make most* kids rather more anxious, wouldn't it, I don't know, obviously they've replicated, they've replicated, whatever, I don't know, I'm just like, [sighs] I need to *think more* about what it is that *disquiets me the most* about this Right attachmenty stuff.

Line 1102: Yeah, I'm not sure, yeah, gosh. No no I'm not sure. I think it is, for me, is like if whatever, it's like nearly *half* sets of parents *appear to get it wrong*, what does that say for evolution [laughs], [unable to hear 1:18:49] it seems monumental that we, you know, parents do such a bad job. Anyway, I do need to give that a lot more thought I think. So what I'll do with it, I don't know, it's kind of an ongoing *musings*, isn't it, really. I suppose *what it is, is helpful, more*, is the *most likely* thing is the continual, particularly with the pre-schoolers, is are we looking at autism spectrum type things, so I think it will yet, as ever, you know help to erm clarify *my* thoughts Yeah and the need to take things, you know, carefully, Hmm and balance up all the other things and what would it look like, and you know. [pause] But I don't think I've been all that challenged of late by the people, I do think that kind of done that for quite a while now, but you have to, you know, pay attention to [pause] autism like, *not just* these very external, oh, well, you know, he's like *wafting* his hands about or he screams every time Yeah you can't come up with a routine, I've kind of, for quite a long time, thought, "Well, you know, let's just consider how [pause] why that might be important and *how* often that's gone on for..." Yeah and blah, blah, blah. Hmm [pause] Now, you've got disquiet about attachment. Mmm. When we were talking about ASD, I wanted to clarify I'd understood your comment about the MMR, "Be clear about her view on this", I've put to myself [laughs]. Oh, right. You know you were saying *parents* were telling you that it seemed to coincide at around fourteen *Yes* months, massive regression..*Yes*. Erm but you were *being told by the research community* that it's not the jab Uh *huh* has it then become your *belief* that it's *not about the jab* and it must be *some other thing* that's happening at that time and it's just sheer coincidence? So I just

wanted to be clear I'd understood *your your personal take on the jab* business, if you had one. Well, I think you've *put your finger on my continuing er disquiet around that*, Hmm is my er [pause] *belief is that the MMR jab* [slow speech] [pause] I could see why people would think it's the MMR jab, because Hmm of the time thing. *However* [staccato and elongated] *the leaky guts and the this, that and the other, my theory that autism isn't just one thing it's probably at least ten Yeah of totally different things is I still kind of think is if you put a cocktail of erm chemicals into kids, would you not expect* [slow speech] certain percentage to erm *react*. Now the genetic thing, isn't it, I don't know enough, I'm not really up to date on the biology, but I *believe* some of the things are saying there are kind of *thresholds* and that certain *environmental factors might just* be enough to trigger these things off, almost like keys or detonate, light the fuse. So I still wonder whether for, whilst it *may well be* perfectly safe for the majority of kids who *don't have a susceptibility*, but you would wonder, you know, I would still wonder whether, for some Okay like there is that and they would come out as, eventually, there would be some kind of, in the *genome*, some little coding that goes, "Ah, right, those with X2457, *they're the ones* Yeah that have reacted to MMR". Yeah, thank you.

It is pertinent to consider whether or not this kind of variation within the profession as expressed in these research discussions, is surprising and also what kind of uniformity of 'taken for granted knowledge' in these domains might be presumed or expected of practitioners by clients (schools for example). One could posit that professional (HCPC) registration, or the demands made by traded services and multi-agency working contexts, might necessitate a greater degree of concordance. An alternative perspective is that the ongoing critical reflection of the type articulated here, is directly compatible with the competency standards required of the professional registration of educational psychologists.

Despite this variation in expressed views, EPs appeared able to practice within uncertainty and discomfort, when the question of 'autism or attachment?' has arisen in a range of practice situations. Next, however, it is pertinent to consider research question 2, How do EPs conceptualise the value of discerning autism from the enduring effects of early attachment experiences?

### 7.3 Research question 2. How do EPs conceptualise the value of discerning autism from the enduring effects of early attachment experiences?

The combined thematic extracts from individual volunteers relating to this question are provided in Appendix M. An exemplifying quote is given here from Volunteer 1 to introduce the reader to the sophistication and complexity of ideas expressed.

Volunteer 1, Interview 3, beginning at line 323

**Line 323: “Because I’ve constantly got the child at the forefront. The child is my *client*, for want of a better word. I’m *working* to make things *better for that child alongside* all the other people that are involved. I’ll *advocate* if I think it’s necessary. I’ll do the assessment, if I think it’s necessary, or talk to the child. Do you know what I mean? Yeah. Yeah.** And, well, and that’s interesting, isn’t it, so [pause] adult A, B or C can sign the form and ask for the input. **Yeah.** So they’re the *commissioner*, **Uh huh** but in *your mind*, **Hmm your belief system**, it’s the child you’re working for, not the person who’s asked for the...? **I will *answer* their question, [pause] but *ultimately*, I’m looking to improve the outcomes for that child. [pause] And if that means I prove or disprove, that is what I do, but I will *always work* to give a *better* understanding and or strategies, or training, *whatever* it is.** So do you see *inherent value* of coming to some sort of conclusion with this dilemma? It’s this or it could be that? Do you see that there is a *purpose* in maybe coming off the fence or...**Yeah....**that it’s a *worthwhile* problem to tussle with? **Yeah.** [pause] *Because* you believe it has direct implications...**Yeah, because, if if [pause] if the *end result* is an accepted diagnosis of, for example, autism** Hmm for that child, and then the people who were *involved reappraise* their practice and *think* about what it is that they’re going to do in the future, then that has had a positive outcome. But, *equally*, what I will say is, during the consultation, for example, we can put these strategies in *now*, and we *should* be putting those strategies in. We shouldn’t have to wait eighteen months. We can do that. But what it will do is *help* people *further down the line as well* understand what is going on, in some cases it opens up a *whole new set of doors* in our authority, because without your diagnosis you can’t access more specialist teaching, without your diagnosis you can’t do this, you can’t do that. Erm and that’s the unfortunate part about labels, isn’t it?”

I identify a number of sophisticated themes within this one quote, provoking a several important questions: who is the client in a piece of work? what is the goal or purpose of EP involvement? and what is the potential for diagnosis to be both helpful and unhelpful?

My overarching impression of the talk generated with these volunteers, is not of a simplistic or clear cut endorsement of the value of discerning possible autism from an attachment presentation. The range of perspectives expressed are illustrated very briefly by comparing the paraphrased

perspectives of Volunteer 5 ('Autism or not, it's a little by the by– I don't engage with those processes) with Volunteer 8 ('At least let's make sure they get the right diagnosis if they are going to get given one, trying to get some distinctions so people don't get the wrong labels and acknowledging both the complexity yet importance of this working on / working out what 'it is').

More apparent was a depth of reflection, caution, and at times distancing from such decision making. The following section speaks to the broad theme of the value that EPs expressed in decision making by examining a number of underlying elements of talk:

- the pros and cons of diagnosis;
- whether diagnosis or 'just' an hypothesis is necessary;
- the role of an EP, and others' expectations of an EP in a given situation.

A summary is provided in Table 13 of my interpretation of the talk relating to the pros and cons of diagnosis.



Table 13 My interpretation of talk relating to the pros and cons of diagnosis.

Pros	Cons
Achieve better understanding	Sets unrealistic expectations of comparable / parallel resources being available in adulthood / adult services to that available whilst at school which isn't necessarily true
Provide strategies	Labels are emotive
Can be helpful	Dangers of labelling – longer term implications
Access to resources / provision	You need diagnosis to access resources / provision (tickets money doors swing into action). Resources / provisions that are geared around criteria and are diagnosis led – the world shouldn't work like this – you can't access resources without them.
Enhance self-understanding, self-affirmation	Could promote negative self-perceptions in individuals concerned
Enhance the understanding of others	Life long term implications – stuck with label for life, set in stone in a medical file, not getting rid of it any time soon,  Absolves others of responsibility for taking action
	Dangers of misdiagnosis – leading to provisions or perspectives that are inappropriate and self-limiting

Whilst EPs did not explicitly refer to an evidence base around functionality of diagnosis, these features of their talk map directly onto some of the ideas presented by Johnstone (2014) which were introduced in the literature view chapter. The pro-decision making notions were that: resources and provision can be accessed upon receiving a diagnosis; supporting adults can re-appraise their practice when they feel they can more fully understand (i.e. that labels / diagnoses can guide practice); diagnosis or decision making can leave practitioners feeling more confident; there is inherent value in discerning autism from attachment to determine what might be the best approach; and that diagnosis can lead to enhanced self-understanding for the individuals concerned.

One implicit assumption here is that labels or diagnoses work directionally to enable professionals take responsibility to act through greater understanding. Gibbs and Elliott (2015) report on work

examining the relationship between conceptual labels and teachers' beliefs about practice in relation to 'dyslexia' and 'reading difficulties'. They concluded,

"the present findings provide a challenge to the value, meaning and impact of certain labels that may be used as 'short- hand' descriptors for the difficulties that some children experience. We suggest that labels such as 'dyslexia' may be of illusory benefit in relation to teachers' efficacy belief. As such they may, therefore, be unhelpful to children's well-being and educational progress" (p232).

The cons or 'downs sides' of labelling expressed included reference to labels as emotive, and as 'catch-alls', Volunteer 2, Interview 1, beginning at line 623,

**"Yeah, and also be aware of the *huge* [elongated] complexity of environmental and genetic and [laughs] Yeah social factors, because, yeah, that's the problem with labelling, how do you pin somebody's er whole way they are on one particular [pause] aspect".**

This echoes the view expressed by Malloy et al (2002) presented in the literature review chapter, where children 'become their diagnosis'. Foroni and Rothbart's (2013) paper explores the effects of labelling. Categorisation, through the application of a label (diagnosis) leads to a loss of individual properties that differentiate people and the simple act of naming a section of a continuum stimulates essentialist assumptions about the category member. De-individualising group members is intimately linked to the process of stereotyping, and stereotyping implicitly means minimising within category differences and accentuating between category differences. As Foroni and Rothbart (2012) propose that "strong categorical labelling systems evoke causal theories that are essentialistic in character" (p574) and obscure differences, so they function 'determinatively'. Perhaps labels function instead to encourage professionals to take less responsibility, through causal alignment with 'within child deficit' discourses, which reflect the essentialist perspective of 'inherent, discrete, natural and stable' properties (Haslam and Rothschild 2000, p125) of the 'category of autism'. Prentice and Miller (2007) point out that those properties have important social consequences; "They shape the way members of essentialised categories are perceived, approached, and evaluated" (p 203). There is some suggestion that 'genetic essentialist' beliefs about mental disorders (and Autism is classified with a manual of mental disorders) promote rather than reduce

stigma (Phelan 2005, cited Haslam and Whelan 2008). This was a perspective shared by Volunteer 3, in interview 2, starting at line 336

Line 336: Er [long pause] I've got a messy picture next [both laugh]. My messy picture is when we started to talk about your thought processes around, not because your account was messy, **Yeah** Me trying to represent it pictorially was messy. Erm I was trying to draw a picture which showed how you *conceptualised* or defined attachment and then autism **Hmm** And, I think, just today, I think we've begun to touch on that again, *about* autism *kind of* being a within child problem because it's neurological, is that right? **Hmm, mmm.** Within child problem, I've got a tongue in cheek there, but is it right that your conceptualisation that it's neurological in origin...? **There's a neurological *aspect* to it, yes, and the idea that [pause] that within child thing, not necessarily with, when I say *within* child, I mean that's that's often a parental and teacher's perspective. So in other words, there's something wrong with him, so therefore [pause] it almost *potentially* could take away from the idea of doing anything about it, to support it environmentally. That's what I mean by that.**

Volunteer 7, Interview I, beginning at line 681,

Line 681: So this is a very *unique* circumstance, have you had this kind of tussling with *what it is* kind of scenario before, before this piece of casework? **Er, in terms of er what are we working with?** Yeah ASD and attachment issues. **Yeah, I mean, I've had it before, but I think there's possibly been *less* levels of complication.** Er mostly in relation to looked after young people, er it's come up, er I think there was a young person who was taken into foster care in one of my high schools, and it came up and one of the, it was a CAMHS worker, not a clinical psychologist had done a piece of work with this young person and said that he should be assessed for autism, er but this young person had had a *really* difficult time in terms of how he'd come into care through *neglect* and all of that route, but this CAMHS practitioner had said, "Although he has got these attachment needs, we also need to look at autism as well", er which was a little bit frustrating because the work that I was doing with my secondary school, I just felt like this was going to be a complete red herring to go through that diagnosis route, er I wasn't sure what it was going to add. I think he was in year ten, maybe, at the time, Hmm I was like, "Hmm, is this helpful focus [laughs] for everybody to be kind of be pursuing, as opposed to Yeah actually just being, yeah, how else could we better use the time to support him", I suppose. Erm but *that* context, yeah, was different in terms of my involvement. Er what might it mean, then, in terms of how you perceive [pause] the place of, the label at the end or the diagnosis, **Hmm** When you're saying about the value that it would add, **Hmm** Does that mean that there's something in there about [pause] how diagnoses or labels add value or not, **Yeah** and how might you conceptualise? **Yeah [sighs] I mean, I think, *for me*, sometimes I become frustrated that that's where everybody's time and energy goes, on following that diagnosis**

route er and looking for this label, as opposed to looking for support solutions, you know, and planning around that, and I think it sometimes *removes* the responsibility from people who are in the environment around them. They possibly feel, "Well, we can't do anything till we get this *label*", and I think it can sometimes be unhelpful in that way in terms of people thinking that responsibility is *beyond them*, and in diverting the focus, I suppose, but some authorities, in terms of support, are diagnosis led, and, you know, for some parents it's helpful, especially when you can't deny that, if that's what parents or people want to pursue. But, for me, as a psychologist, sometimes I just think it takes us off on a **tangent that could, that isn't always that helpful.** [long pause] And it's a tangent *because* you would rather be.. I'm doing a sentence...[Laughs]. ...I'm doing a sentence completion activity in my head thinking [name] will finish this! [Laughs]. So, *if* [pause] some local authorities are focus led...**Diagnosis.** Diagnosis led...**In terms of support** Yeah **that you can access, so access to particular teams that might then support in the home Yeah or the school or things like that, I suppose.** But then you've clearly labelled yourself, '*but as a psychologist*', so thinking about your professional role, you said that that can place you at a *tangent*, or feel that that's at a tangent, and feel that it's not always helpful? **No, sometimes I just think it, people think, kind of focus on that (unable to hear 46:58) as opposed to thinking, "Well, let's look at this as a problem solving process *now*, what can we do *now* with this situation", the behaviours are still going to present, as I say, whether he gets that diagnosis or not [laughs], and we're still going to have to or the needs work with those and put provision in place that, "Let's look at what skills, what we need to support, what needs he might *have* and work with that", and, I think, sometimes in a sense of *holding off* until we get this diagnosis, that could be a year down the line [laughs] Yeah and I think it's about, well, also people's confidence in managing it as well, "Oh well, if we don't know what it is, then I don't want to do that in case I get that wrong or..."Yeah You know.**

There were occasions where the same consequences of diagnoses were viewed both positively and negatively at the same time. An example is of access to resources or provision. It was expressed positively that following diagnosis individuals could 'get what they needed'; whilst organisation of and access to 'diagnosis- led local authority provision' was also lamented as a practice. The first person account of the 'double edged sword' of diagnosis in 'Autism diagnosis and the walled garden' (Author withheld, BPS, NE Branch 2016) and The Trainee Educational Psychology Conference in 2016

entitled, "Do labels and diagnoses help or hinder?" reflect the ongoing consideration of the pervasive power of diagnosis, or labelling / categorisation within the profession of Educational Psychology.

Hypothesis generation was expressed as problem analysis falling short of and a little different to proceeding to diagnosis and was expressed as a worthwhile endeavour as a primary focus when circumstances allow. Illustrative examples are taken from Volunteer 3, Interview 2, beginning at line 740,

Line 740: We're talking about encouraging reflection, reminding them to take time, which you reiterated, trying to be *logical* and do your, "What's going on, what are you seeing, then go through your process, what are all the things it could *possibly be*, **Yeah** and then *whittling* them down looking for reasons". **Yeah, and I think I would add to that, [pause] Not, "Don't necessarily feel that there has to be a label", because Yeah Even attachment is a label of sorts, "Don't get too bound up in *that*, but think about *why* this child is behaving like that and *therefore* what does that *mean* in terms of meeting that child's *needs*, rather than thinking about, "Why is that child acting like that? Oh, that must mean it is""**, do you see the difference? Yeah. So, actually, trying to, yeah, you need those *models* in your head, you do need those models because that will then inform (unable to hear 1:01:43) *but* don't be a *slave* to them, I think that's what I will say and feel that you have to [laughs] Yeah it has to fit (unable to hear 1:01:52). So, in our team meetings, when we did the activity theory thing around EP practice and statutory assessment and report writing, EPs are providing a piece of psychological advice for the local authority, do you remember that line? **Yeah.** Object, goal, Yeah So we're providing advice, *so that* we can meet the needs of. **Yes** Is the end goal of this activity to meet needs rather than give it a name, in your view? **Yes, absolutely, yes, thank you. You've articulated it *brilliantly*, thank you, Fiona [laughs]. That's exactly what I mean.**

and Volunteer 8, Interview 1, beginning at line 47,

Line 47: I honestly don't think I've *ever* really sat down and thought it through *explicitly*. I think we got *close* to it when I was one of the *diagnostic team members* and where we did have some discussions where we couldn't *resolve them* because we didn't have a framework or anything else. It was kind of hunches or erm best guessing really, or just talking around, *occasionally* it would come up to say, *given* what we *know* have we tried, and that's where, well, but you might come on to that, but is that where, maybe, erm we *balance out* the strength of information say from intervention, if we're confident that a *good* period of structured intervention *had been tried*, but not resolved the difficulties or whatever. Right That might have come up, but that would be the only context, I think, would be *in the diagnostic* Yeah for autism team. So yeah, I suppose, you know, like a lot of what we do, not know that it always *really matters* whether you can reach the conclusion, it's *whether* you, [pause] whether you've got *enough to consider things*. I don't know that you always need Hmm to be able to *reach* the conclusion to make the next step, do you, you just maybe, it's enough to identify that this is an area of difficulty or an area

**that erm people want to focus on Yeah and want ideas around. They don't need to know kind of where it came from, if you know what I mean, maybe.**

Talk as exemplified in these extracts correspond with the view expressed by Johnstone (2014) “you don't need a diagnosis to be clear what kind of problem someone is experiencing” (p43). The position that meeting need, regardless of underlying cause is appropriate and achievable as might be inferred here, is worthy of further consideration. For example, different views on this have been indicated by the same author as noted in the literature review chapters. Moran's (2010) paper indicated that some types of intervention might help both autism and attachment problems, yet, in her later paper (2012), she noted,

“The way we might help a child will depend heavily upon our professional construction of their difficulties, with diagnosis being an important signpost rather than a destination. The best way to start intervening will be quite different for a child with ASD compared with a child with attachment problems (p17).

EPs' talk also suggested that the contexts and pressures within which they work can influence the focus of their activity. One example from Volunteer 7 was the employing local authority's expectations of an EP in a statutory assessment process (to advise the LA about provision where resources / provision are 'diagnosis led', rather than matched to presenting need). Tension or contradiction was noted when preferred EP activity might have been focused on meeting presenting need as opposed to arriving at a conclusion or diagnostic opinion / signpost. Further, within a multi-agency context, others' expectations of the EP role (as diagnosers or labellers, finding out what was wrong or providing 'an answer' as to why a child behaves a certain way) could make the exercise of professional autonomy (determining what kind of activity is most appropriate at a given point in time in specific circumstances) problematic. Volunteer 7 also spoke of how the foci of her work changed during the course of involvement; from hypothesising (understanding the communication and emotional needs of a child), to containing staff when the child's behaviour deteriorated, and returning to a renewed focus on hypothesising as her involvement drew to a close.

**Line 314: Who else was there? It was massive. Probably one of the biggest case conferences that I've kind of ever been to in terms of numbers** Right **and, yeah, it was quite quite tricky.** So [elongated] [both laugh], so we're starting to get a picture of things that were happening, things that were done, **Yeah** and you've also given me a flavour, or started to develop a flavour of what it was like at *first Yeah* and then what happened. **Yeah, and where it moved to** er in terms of the things you were doing. [long pause] I'm wondering if you've also started to talk about what you were *thinking*, sort of what knowledge and understanding you were *drawing* on, because you've talked about hypotheses or formulations **Hmm** that were flying around, neglect, abuse, attachment...**Language needs**....language, and autism spectrum condition. **Yeah.** Er [pause] is there a way in which you *felt* that you were *drawing* on particular things, in terms of *this pressure* you were under? **Hmm** I think, initially, er there was, I think I was coming from the perspective of his language needs, and not been able to express those needs and strategies around kind of communication. Er as the kind of background history of the family kind of evolved and all the child protection, I think we looked more about emotional needs, and also as his presentation became more *extreme* in terms of what, obviously, he was trying to communicate to us, we were looking at more nurture and more soothing, more *practical* ways to help him feel better, Yeah I suppose, to manage some of those emotions, and I think, also as his behaviour escalated and became more physical towards staff and other young people and more sexualised, staff anxiety levels and emotions *also* rose, so I think *my role* became a lot more *containing* rather than, and that *possibly* distracted from some of the *hypothesising* Ah! because I think it was more *reacting* from containing staff and I think it was only possibly towards me *leaving the service* when I started to put together quite a comprehensive report, that I started to go back to that kind of hypothesising, Right because it was doing that containing that made me, took the priority. Er if you know what I mean ([laughs]).Yeah, I can see how, following the pattern of the casework, if you like, Yeah how our attention can get *drawn* Yeah to certain parts of it, can't it? Yeah, Er because you're *in amongst*, I suppose, all of that *emotion* and all of that *staff stress* and you *just* want to try and make that a bit better at the time, without having that, it's hard to keep that *bird's eye view* on actually what else, what are we working with here? And I guess, at that point in time, from the school staff, they didn't *care* what it was, whether it was autism, whether it was this, I suppose they just wanted to, this boy that was coming in really distressed, make that situation better, obviously, in terms of social care and the other people who were in the case conference, they were saying, "Well, do we need a CAMHS referral? Do we need this? Do we need a diagnosis?" Right and that pressure was coming from them but not necessarily from the school because they wanted to know *how* do we deal with this on a day-to-day basis and try and meet his needs, I suppose. Did you feel there *was* a difference, then, in *motivation* or was the underlying motivation, so staff say, "I don't care *what* it is, he needs help and tell us how to help him". **Yeah.** Yeah, and you've got the *pressure* from the case conference then, "We need to know what it is, what do we need to do?" **Yeah.** Now, [pause] is it the same motivation because he needs help, or was it about ruling things in and ruling things out and, [pause] **Yeah** Would it have put people off looking at abuse if they could say he was autistic? **I know, yeah...** Would that...? I think they were trying to get an understanding, I suppose, of what his behaviour was communicating. Is this a young person that's in *distress* because of something they've *experienced*, or is it a young person that's in distress because of his *sensory needs*, is it *both*, is it, you know, Yeah that kind of, and, I suppose, there is a sense of we need to be seen to be checking *everything*, *every* possible avenue, like, whether that's to be covering our backs motivation [laughs], Yeah or to be getting to the root of this, er you know, in

terms of *what* his needs *are*.

My overarching impression of talk on this topic was that volunteers reported exercising caution and did not engage in the activity of hypothesising uncritically. Rather, talk indicated that EPs evaluate the costs and benefits of differential decision making on an individual basis in their unique set of circumstances.

My interpretation of talk presented so far is summarised as follows. EPs remain reflective about both their knowledge bases and the accepted state of the wider research knowledge. Many spoke of the factors that influenced their practice in this area; the contextual backdrop in casework examples, the perceived expectations of others of their role and the need for due consideration of a cost benefit analysis of decision making in individual circumstances.



7.4 Research question 3a. How do EPs conceptualise the overlapping phenomenology? (In making statements like this, “It looks more like attachment” in the context of a possibility of ASD, what do EPs mean?)

7.4.1 Overlapping phenomenology

Findings in respect of this third research question are presented in two parts; the first addressing the talk concerning overlapping phenomenology and the second, addressing talk concerning the problem analysis processes. The Coventry Grid Version 2 (Moran 2015) was introduced in Chapter 4 (subsection 4.4.1) as a document which captures the views of a group of professionals about the overlapping phenomenology. Talk about overlapping phenomenology presented through the course of discussion across volunteers were extracted, collated and then cross referenced with the Coventry Grid Version 2 for examination of additionality. This subsection presents the Coventry Grid Version 2 with those additions from the current study shown in red text in Table 14.

Table 14. **COVENTRY GRID VERSION 2 WITH ADDITIONS FROM THE CURRENT STUDY (shown in red)**

### How to use this grid

No two children are the same – it is important to look for a pattern across a number of areas and features are not mutually exclusive. Presence of some features might make decision making ‘more obvious’ such as speaking with an American accent and stereotypies such as hand flapping (Vol 2), as could the absence of others (such as lack of special / unusual interests or language idiosyncrasies Vol 3). A detailed history is required in both cases to help with decision making around likely causation, and even coexistence (Vol 2).

#### 1. Flexible thinking and behaviour

Children and young people with Autistic Spectrum Disorder and those significant attachment problems and disorders **can** present with **anxious behaviour**, **appear to need predictability and show responses to something different happening (Vol 3) underlined by** difficulties with flexible thinking and behaviour. Their behaviour can be demanding and ritualistic, with a strong element of control over other people and their environment. The different ‘flavour’ seems to be about personality style, a strongly cognitive approach to the world in Autistic Spectrum Disorder, and a strongly emotional approach in children with problematic attachment (**an articulation for things rather than people**) (Vol 8). The need for predictability in children with problematic attachments suggests that the child is trying to have their emotional needs for security and identity met. In Autistic Spectrum Disorder, the emphasis seems to be on trying to make the world ‘fit’ with the child/young person’s preference for order and routine. **Both potentially better settled by routines / predictability (Vol 8). The degree of inflexibility in an individual’s outlook and the way in which that is communicated might indicate whether the underlying driver is Autism or attachment related behaviour Vol 2)**

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Typical presentation in Attachment Problems
<b>1. Lack of flexibility of thought and behaviour</b>	1.1 Preference for predictability in daily life	<ul style="list-style-type: none"> <li>• Repetitive questions related to own intense interests</li> <li>• Repetitive questioning re changes in routines and new experiences</li> <li>• Ritualised greetings</li> <li>• Becomes anxious if routine is removed and may seek to impose usual routine (e.g. wants same bedtime routine when away on holidays; won’t accept the supply teacher)</li> </ul>	<p>Preference for ritualised caring processes (e.g. bedtimes, meals)</p> <ul style="list-style-type: none"> <li>• Repetitive questioning re changes in routines and new experiences</li> <li>• Copes better with predictability in daily routines but usually enjoys change and celebrations</li> </ul>

		<ul style="list-style-type: none"> <li>• Inclined to try to repeat experiences and to interpret any repetition as routine (e.g. asks/demands repetition of following the same route to school; cannot cope with a change to appointments)</li> <li>• Prefer order and sameness so new experiences disrupt that sense of order and sameness – need to establish an understanding of rules / shape of experience for it to be ‘assimilated’ (Vol 3)</li> <li>• Distressed when a routine or ritual cannot be completed (e.g. when cannot follow the usual route because of road works)</li> </ul> <p>Like the same fixed routine, they like routines because they like things to go the same (Vol 8)</p> <p>Particularly like clear rules (Vol 8)</p> <p>Routines and rules have a re-assuring function (Vol 8)</p> <p>More likely to have non-functional routines (Vol 8)</p> <ul style="list-style-type: none"> <li>• Appearing fixed in views through a belief in correctness and a lack of appreciation of others’ perspectives (factual basis) (Vol 2)</li> </ul>	<ul style="list-style-type: none"> <li>• Looks forward to new experiences but may not manage the emotions they provoke (e.g. may not cope with excitement or disappointment) May look forward to new experiences but find it difficult to contain anxiety / the uncertainty that they arouse (Vol 3)</li> <li>• Takes time to learn new routines</li> <li>• Routines tend to be imposed by adults in order to contain the child’s behaviour more easily Might take longer to adjust to and learn new routines as they are not such ‘pattern seekers’ and may not have learned that patterns are a good thing (Vol 8)</li> </ul> <p>May in fact resist (rather than welcome) the adults imposition of routine / control (Vol 8) as adults are not to be trusted to meet your needs, therefore unsafe to allow them to be in control (R) – learned self-reliance</p> <p>May want to take over the imposed rules / put their own stamp on things to take some control back (Vol 8)</p> <p>Imposing routines could become the site of a power struggle where child wants control within that routine Less likely to have non-functional routines (Vol 8)</p> <p>Appearing fixed in views so as to maintain control (omnipotence) / in charge (emotional basis) (Vol 2)</p> <p>Rigidity may appear less predictable (Vol 2)</p> <p>Rigidity is imposed to guard against anxiety (provoking situations) (Vol 2)</p>
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		<ul style="list-style-type: none"> <li>• Rigidity can be seen across a range of functioning (play, learning, social relationships but more likely to identify a pattern when you know the person well) (Vol 2)</li> <li>• Differences in your thought patterns (when compared with other peoples') induces anxiety (Vol 2)</li> </ul> <p>Response to change - Could be resistant to change (Vol 1)</p>	<p>Could be resistant to change but then may actually like it (Vol 1)</p>
	1.2 Difficulties with eating	<ul style="list-style-type: none"> <li>• May limit foods eaten according to unusual criteria such as texture, shape, colour, make, situation, rather than what that food is (e.g. will eat chicken nuggets but no other chicken)</li> <li>• May adjust eating because of literal understanding of healthy eating messages (e.g. sell-by dates, avoidance of fat)</li> <li>• Restricted diet seems to be about maintaining sameness and the child is not easily encouraged by people the child is attached to</li> <li>• Connection between high functioning ASD and eating disorders during adolescence</li> </ul>	<ul style="list-style-type: none"> <li>• Anxious about the provision of food and may over-eat (or try to) if unlimited food is available</li> <li>• May be unable to eat when anxious</li> <li>• May hoard food but not eat it</li> <li>• May be unable to eat much at a sitting</li> <li>• May 'crave' foods high in carbohydrate</li> <li>• Eating is transferable from situation to situation and the child can be persuaded by close adults</li> <li>• Children tend to have a range of eating disorders</li> </ul>
	1.3 Repetitive use of language	<ul style="list-style-type: none"> <li>• Echolalia</li> <li>• Repetition of 'favoured' words which are chosen for their sound or shape, rather than for their use in communication or emotional content</li> </ul>	<ul style="list-style-type: none"> <li>• May develop rituals for anxiety provoking situations (e.g. says same things in same order when saying goodnight or leaving for school)</li> <li>• Older young people's self-comforting may take</li> </ul>

		<ul style="list-style-type: none"> <li>• Children's repetitiveness is out of synch with their developmental stage</li> <li>• May use formal or inappropriate language which they don't understand (incorrect use of words/phrases).</li> </ul>	<p>form of substance misuse/self-harming</p> <ul style="list-style-type: none"> <li>• Children's repetitive seems to be like that of a younger child – learning and playing with language</li> </ul>
	1.4 Unusual relationship with treasured possessions	<ul style="list-style-type: none"> <li>• Often uses possessions as ornaments, especially making collections of objects, but does not seek social approval for the collection or for its care</li> <li>• Will often be able to say where most treasured possessions are and recognise if they are moved</li> <li>• May be unable to dispose of old toys/papers/books even though they are not used</li> <li>• Shows a preference for old, familiar items (or toys/items which are part of a series) rather than new and different toys</li> <li>• Can be a mismatch between the amount of theoretical knowledge they have and their social use of that knowledge e.g. aware of football facts but doesn't share it socially.</li> </ul>	<ul style="list-style-type: none"> <li>• May seek social approval/envy from others for Possessions</li> <li>• May not take extra care with possessions which have been given an emotional importance</li> <li>• May be destructive with toys, exploring them and breaking them accidentally</li> <li>• New and different toys are appreciated</li> <li>• May lose things easily, even most treasured possessions, and may be unable to accept any responsibility for the loss</li> <li>• May deliberately destroy emotionally significant possessions when angry</li> </ul>

## 2. Play

Play is a clear problem in both groups of children/young people, with a lack of imagination and an inclination towards repetitiveness evident in both Autistic Spectrum Disorder and significant attachment problems. The difference seems to lie in what the way the children/young people play and use their recreational time: those with Autistic Spectrum Disorder are inclined to choose toys which are related to their intense interests and to play with those toys by mimicking what they have seen on DVDs and television. They may also choose play that is cognitive and characterised by collecting and ordering information, such as train spotting or reading bus timetables, and involves little emotional contact with other people. **Play is more likely to be solitary, repetitive and involve organising (lining things up) (Vol 8).** Children/young people with significant attachment problems may lack play skills but their play interests tend to be more usual. **Their play is more likely to include acting out things that have happened (negative experiences, not just role play) (Vol 8)**

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
2. Play	2.1 Poor turn taking and poor losing	<ul style="list-style-type: none"> <li>• May try to impose own rules on games</li> <li>• May see eventually losing a game as unfair if was winning earlier in the game</li> <li>• Preference for playing alone or in parallel with others</li> <li>• Interests may be not be age appropriate and narrow.</li> </ul> <p><b>May give out roles to others but may not change roles around (Vol 8)</b></p>	<ul style="list-style-type: none"> <li>• May try to impose own rules on games so that they win</li> <li>• May be angry or upset about losing games and blame others or the equipment for their failure (there is a sense of fragile self-esteem in the style of reaction)</li> <li>• Preference for playing with others who can watch them win</li> <li>• Interests are more usual/age appropriate but response to the activity is emotionally driven.</li> </ul> <p><b>May boss and be in charge and give out roles but perhaps be more charming / polite in getting their way (Vol 8)</b></p> <p><b>More likely to act up, spoil the play, challenge an adult (Vol 8)</b></p>
	2.2 Poor play with toys	<ul style="list-style-type: none"> <li>• Plays with toys as objects rather than personifying Them</li> <li>• May spend all time organising toys and arranging in</li> </ul>	<ul style="list-style-type: none"> <li>• Uses possessions &amp; actions to engage the attention of other children</li> <li>• May play games which include own experience of</li> </ul>

		<p>patterns (e.g. ordering by size, colour)</p> <ul style="list-style-type: none"> <li>• May 'play' with unusual things (e.g. reading the telephone book, watching water run down the drain) for long periods from a young age</li> </ul> <p>More likely to play with non-toys (including faeces) and have some obsessional item (Vol 8)</p>	<p>traumatic life events and difficult relationships</p> <ul style="list-style-type: none"> <li>• May have poor concentration on activities and be able to play alone only for very brief periods (or be able to be alone briefly)</li> </ul> <p>Play with more typical things, the things other children play with, and have more glimpses of typical play (Vol 8)</p>
	2.3 Poor social play	<ul style="list-style-type: none"> <li>• Dislike and avoidance of others joining in play</li> <li>• Lacks interest in social play with parents/carers</li> </ul> <p>Adults might be able to parallel play, adults might not be involved in the play as children may lack the idea of adults as potential participants (Vol 8)</p> <p>Both might have a low tolerance of other children and push children away / get cross (Vol 8)</p> <p>May copy others (without an understanding), thereby mirroring without being connected to the 'fun' part (Vol 8)</p> <p>You may be involved in 'playing' but actually get no reaction (Vol 8)</p>	<ul style="list-style-type: none"> <li>• Relies upon adults to provide play opportunities and/or to direct play</li> <li>• May prefer to play with adults (esp. carers) rather than children</li> </ul> <p>May want adults attention in play – they have an idea of adults as a potential participant (Vol 8)</p> <p>Both might have a low tolerance of other children and push children away / get cross (Vol 8)</p> <p>May get more acknowledgement in play (Vol 8)</p>
	2.4 Repetitive play	<ul style="list-style-type: none"> <li>• Lack of interest in developing a range of play</li> <li>• Strong preference for the familiar and tendency to play alone for long periods</li> </ul>	<ul style="list-style-type: none"> <li>• Plays repetitively with adults much as a toddler likes to play such as hide and seek, lap games</li> <li>• Plays out past experiences and preferred endings repeatedly (e.g. escaping from danger, saving siblings)</li> </ul>
	2.5 Poor imaginative play	<ul style="list-style-type: none"> <li>• Difficulty playing a variety of roles within games</li> </ul> <p>What might appear imaginative play may actually be copied from somewhere else, repeated daily – need to watch closely and over time to identify 'scripting' (Vol 8)</p>	<p>Play perhaps more imaginative than in autism (Vol 8)</p> <p>May be associated with violent play (Vol 8)</p> <p>May lack imagination in play but can appear appropriate for an earlier developmental level / developmentally delayed but appropriate (Vol 8)</p>

		<p>Role play is actually 'sticking to scripts' and annoyance when play is off-script as content is important (Vol 8)</p> <ul style="list-style-type: none"> <li>• Difficulty incorporating a range of toys into the same game (e.g. using both Dr Who and Spiderman toys in a game)</li> <li>• Preference for toys which have a mechanical rather than emotional nature (e.g. cars, trains, Lego) or which require logic and order (e.g. reviewing and organising collections of objects) or examining objects (e.g. watching spinning objects)</li> </ul> <p>May have difficulties pretending (doing the action of having a drink without holding a cup) or understanding miming as representing real actions with real objects i.e. difficulties with mime (Vol 8)</p>	<p>More likely to argue over roles and less so about content going to script (Vol 8)</p> <p>Difficulty ending role play games</p> <ul style="list-style-type: none"> <li>• May be able to take various roles but may show a strong preference for a kind of role (e.g. always the baby, always the angry father)</li> <li>• May not seem to enjoy solo imaginative play and lose interest but can play imaginatively with another person</li> </ul>
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### 3. Social interaction

There are key similarities in social interaction: children/young people in both groups tend to have an egocentric style of relationship with other people and lack awareness of the subtle variations in social interaction which are necessary to develop successful relationships with a range of other people

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
<b>3. Poor social interaction</b>	<p>3.1 Difficulties with social interaction</p> <p>3.2 More successful in interactions with adults than peers</p> <p>3.3 Own needs drive interactions</p> <p>3.4 Lacks awareness of risk and personal danger in interactions with adults</p>	<ul style="list-style-type: none"> <li>• Interaction is usually one-sided and egocentric with little regard for the response of the audience</li> <li>• Does not often manipulate others emotionally except through angry outbursts (i.e. would rarely ingratiate self with audience)</li> <li>• May perform better in less emotional situations</li> <li>• Poor awareness of own role in interactions</li> <li>• Lack of social imagination – can't imagine what risks might be associated with certain peer /adult relationships (it can look similar to attachment in need to make friends)</li> </ul>	<ul style="list-style-type: none"> <li>• Seeks an emotionally expressive audience for interactions (e.g. seeks to provoke strong reactions in audience such as anger, sympathy, support, approval)</li> <li>• May make persistent attempts to interact with adults or older children rather than with age peers</li> <li>• May initiate interactions with others which allow them frequently to play the same role in relation to self (e.g. as the victim, as the bully). We need to look at the relationships and see what need it meets. In attachment it is likely to be meeting an emotional need, possibly to do with pleasing others.</li> </ul>
	3.5 Difficulty sharing and	<ul style="list-style-type: none"> <li>• Lacks awareness of the social expectation that the child will share (because the child does not understand or need</li> </ul>	<ul style="list-style-type: none"> <li>• Aware of the social need to share but anxious about sharing (especially food) and may refuse or hoard or hide</li> </ul>

	working in a group	<p>the social approval of others)</p> <ul style="list-style-type: none"> <li>• May not realise the needs of others waiting for their turn</li> </ul>	<p>possessions and food to avoid sharing</p> <ul style="list-style-type: none"> <li>• May take things which are important to others with awareness that this will be upsetting for the other person</li> </ul>
	3.6. "I"	What do they offer that starts with, "I"...? (Vol 8)	Emotionally based extreme "I" statements. I'm rubbish, I can't, I'm the best, I've been to America, I can drive to the point of lying about skills (Vol 8)
	3.7	Both may lack perseverance and give up rather than give a don't know answer - May be equally as naïve about adults but less likely to make outlandish claims (Vol 8)	Perhaps through lack of adult feedback they've learned that they'll not be 'caught' saying such things (Vol 8)

#### 4. Mind reading

Both groups have difficulties taking the perspective of another person and reading intentions. **Both could be confused about other people's intentions / feelings (theory of mind) (Vol 8)**

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
<b>4. Mind reading</b>	4.1 Difficulty Appreciating others' views and thoughts	<ul style="list-style-type: none"> <li>• Rarely refers to the views of others</li> </ul>	<ul style="list-style-type: none"> <li>• May be manipulative (or overly compliant) and ingratiate self with adults/children</li> </ul>
	4.2 Lack of appreciation of how others may see them	<ul style="list-style-type: none"> <li>• Lacks awareness of other's views of self, including lack of awareness of 'visibility' of own difficulties (e.g. may volunteer to perform gym sequence even though child is very poor at gym)</li> <li>• Does not appreciate the information parents would like to hear about successes and enjoyment</li> </ul>	<ul style="list-style-type: none"> <li>• Inclined to blame others for own mistakes</li> <li>• Draws attention away from own failures towards own successes</li> <li>• May try to shape others' views of self by biased/exaggerated reporting</li> </ul>
	4.3 Limited use of emotional language	<ul style="list-style-type: none"> <li>• Rarely refers to the emotional states of self and others</li> </ul>	<ul style="list-style-type: none"> <li>• Hyper-vigilant with regard to particular emotions in others (e.g. anger, distress, approval) and often makes reference to these states</li> <li>• Poor emotional vocabulary</li> </ul>
	4.4 Problems distinguishing between fact and fiction	<ul style="list-style-type: none"> <li>• May not realise that cartoons, toys, animations and science fiction are not real</li> <li>• May not realise that fantasy play is a temporary role</li> </ul>	<ul style="list-style-type: none"> <li>• Tendency to see self as more powerful and able to overcome enemies, or as vulnerable and powerless to offer any challenge</li> <li>• May talk repeatedly of how to overcome captors/escape</li> </ul>

	<p>4.5 Lying (Vol 8)</p> <ul style="list-style-type: none"> <li>• May be easily influenced by fantastic claims and advertising</li> <li>• Lies are often easily discovered and 'immature' in style</li> </ul> <p>Generally doesn't, but when does, is pretty obvious (Vol 8)</p> <p>More likely to get into trouble for 'spragging on people' and telling the truth (Vol 8)</p> <p>May seem to stick with 'telling lies' (even when 'caught in the act' and therefore observed to be in the wrong) but individual does not genuinely appreciate their role in an incident and often their accounts remain stuck or focused on another person's role earlier on in a chain of events (R)</p> <p>Will deny (or not acknowledge) their role in a situation and instead focus on what someone else did (wrong) (which can be thought of as lying) (Vol 8)</p> <p>May come out with bold statements as they've not understood the difference between fiction / non-fiction (reality versus cartoons) – they've taken everything they seen as equally valid (Vol 8)</p> <p>Less likely to get 'pretending' (vol 8)</p>	<p>from imprisonment/kill enemies even when these adversaries are obviously bigger, stronger and more powerful than the child</p> <ul style="list-style-type: none"> <li>• May not be able to judge whether a threat is realistic and act as if all threats, however minor or unrealistic, need to be defended against</li> <li>• Lies may be elaborate and also may deliberately be harmful to others' reputations and designed to impress the audience</li> </ul> <p>May be more manipulative in terms of lying (Vol 8)</p> <p>More likely to lie to get others into trouble and get self out of trouble</p> <p>More likely to blame others (Vol 8)</p> <p>May come out with quite bold lies along the lines of Action Man, "I kicked his head in" and say power related things "I'm gonna kill you", voicing fantasies that they are bigger / scarier / stronger (that their body would suggest) (Vol 8)</p> <p>They 'get' pretending but take things too far and then can't get themselves back (Vol 8)</p>
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	4.5 Stealing (Vol 8)	<p>Both might like to collect things but more likely to collect (take / steal) things they like / value (Vol 8)</p> <p>Once they realise stealing is against the rules / is wrong they would be less likely to do this secretly (Vol 8)</p> <p>Will be less successful in getting something without the owner's knowledge (Vol 8)</p> <p>Following rules / honesty would override 'I need / want it' (Vol 8)</p> <p>There might be an innocence in taking, perhaps leaving items in fairly broad view once taken (Vol 8)</p>	<p>Both might like to collect things but more likely to take / steal / covet things of value to others, not necessarily what they value (Vol 8)</p> <p>Stealing could be needs led (e.g. food if believing needs will not be met)</p> <p>More likely to be manipulative, secretive, deceptive in the taking despite knowing the rules (Vol 8)</p> <p>Might steal things if others have shown off and therefore items have value to their owners (Vol 8)</p>
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## 5. Communication

There are many areas of similarity in the social communication difficulties because they are about the subtleties of communication. **The impact on you may feel emotionally different but the outcome could be the same – you don't get what you want out of the assessment / interaction (Vol 8) Both may struggle with the skills needed but the way these struggles typically present is different (Vol 8). Both may have patchy vocabulary (Vol 8)**

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
5. Communication	5.1 Pragmatic language problems	<ul style="list-style-type: none"> <li>• Poor awareness of the purpose of communication</li> <li>• Lacks awareness of needs of audience</li> <li>• Does not repair communication break down</li> <li>• Poor eye contact (may be fleeting, staring, is not synchronised with verbal communication)</li> <li>• Proximity does not signal intimacy or desire for contact</li> <li>• Often does not start conversation by addressing the person</li> <li>• Conversation is stilted</li> <li>• The burden of communication lies with the listener/adult</li> <li>• Assumes prior knowledge of listener</li> </ul> <p><b>Both may try to do something else when faced with</b></p>	<ul style="list-style-type: none"> <li>• Lack of attention to the needs of the listener through poor attention to communication (due to poor modelling)</li> <li>• Eye contact affected by emotional state</li> <li>• May be overly sensitive to voice tone, volume and stance of speaker (hyper vigilant to potential emotional rejection)</li> <li>• Better able to initiate conversation</li> <li>• May be overly sensitive to voice tone, volume and stance of speaker (hyper vigilant to potential emotional rejection)</li> <li>• Non-verbal communication may be delayed (this includes reading of facial expressions &amp; gestures) but progress can be good with intervention. This can vary depending on type of attachment difficulties.</li> <li>• Can be hyper vigilant; often described as manipulative because of poor emotional regulation</li> </ul>

	<p>Interaction with adults (Vol 3) and reactions to unfamiliar adults within class</p>	<p>difficulty in communication - May try to change the topic - Would rather change the subject to something they know the answer to (Vol 8)</p> <p>May provide absolutely no response (no look, no explanation, almost as if the question doesn't register) to questions that they don't know the answer to, instead of saying I don't know (Vol 8)</p> <p>As an interactive partner you may feel puzzled, very suddenly cut-off as child is blunt, can be rude and matter of fact but isn't seeking a reaction in being so. You can feel stumped as to what is going on (Vol 8)</p> <p>May lack an interest in other people (Vol 2)</p> <p>May lack skills in knowing how to communicate with other people (Vol 2)</p> <p>Difficulties sharing based on rules / appreciating others' needs, not wanting others in their space, others getting in the way of them doing their own thing (Vol 2)</p> <p>Lack of knowledge / insight into social conventions (Vol 2)</p> <p>Both may use people to get their needs met - To get other (non -emotional) kinds of needs met (Vol 2)</p> <p>Less / no emotional investment in interaction / less interest in you as a person (Vol 2)</p> <p>Talking to adults not a problem in itself (for ASD – you may either get an ignore response as if your request doesn't register or socially awkward / lack of reciprocity type interaction – talking to you about what they want</p>	<p>May try to change the topic - Would rather change the subject to something they know the answer to (Vol 8)</p> <p>Less likely to provide no response at all (Vol 8)</p> <p>As an interactive partner you tend to feel more frustrated with them, you may try persuasion, they'll appear to go for offers and deals but are actually quite controlling and you get enmeshed a little bit but there is more of a social engagement. There might be a charm and you may feel persuasion will work but there is a sour feel (Vol 8)</p> <p>May lack trust in other people which can be an / the underlying source of difficulty (rather than a deficit in communication skills / ability) (Vol 2)</p> <p>Has skills (more likely to have skills) but lacks trust (Vol 2)</p> <p>Difficulties sharing linked to emotions (being in control / in charge / powerful) (Vol 2)</p> <p>Lack of social inhibition (Vol 2)</p> <p>Emotional needs (survival) (Vol 2)</p> <p>Has an inherent interest in having an interaction and a reaction from you (Vol 2)</p> <p>In attachment a direct perception of threat may affect the quality of interaction (Vol 3)</p> <p>Attachment – more likely to perceive unknown adults as a</p>
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		<p>to talk about) (Vol 3)</p> <p>ASD responses might be blunt / direct yet functionally inquisitive (what are you doing here?) the tone of voice conveying factual information seeking (Vol 3)</p> <p>On articulating the different 'feel' in terms of social interaction between ASD and attachment - as opposed to responding from a naïve position (who are you?) (Vol 3)</p>	<p>threat (who's she and what is she doing here?) – the tone of voice conveys a different intention behind asking (Vol 3) (gauging / assessment of potential threat (related to hypervigilance?) (R) (responding from a threatened position (who are you?) (Vol 3)</p>
	5.2 Poor understanding of inferred meaning, jokes, sarcasm and gentle teasing	<ul style="list-style-type: none"> <li>• Poor understanding of idiomatic language</li> </ul>	<ul style="list-style-type: none"> <li>• Gentle teasing may provoke extreme distress (self-esteem seems to be too fragile to cope) – internalise/assume it is about them</li> <li>• Poor understanding of idiomatic language (and may take misunderstandings personally).</li> </ul>
	5.3 Use of noise instead of speech	<ul style="list-style-type: none"> <li>• Makes noises for personal pleasure (as with favourite words) e.g. barking</li> </ul>	<ul style="list-style-type: none"> <li>• Attention-seeking noises (e.g. screams/screeches/whines under stress) to signal emotional needs and wishes</li> </ul>
	5.4 Vocabulary	<ul style="list-style-type: none"> <li>• May have word-finding problems</li> <li>• Often have unusually good vocabulary (for age, or cognitive ability, or within specific interest areas)</li> <li>• Less use of vocabulary related to emotions</li> </ul>	<ul style="list-style-type: none"> <li>• Often poor vocabulary range for age and ability</li> <li>• May use more emotive vocabulary (to get needs met)</li> <li>• Often poor vocabulary range for age and ability acute by the time they get to adolescence.</li> <li>• May use more emotive vocabulary (to get needs met) Lots of basic negative vocab around anger, much fewer vocab items known to describe other emotions.</li> </ul>



		<p>May have vocabulary related to objects, especially those of their own interests, may be poorer around people (Vol 8)</p> <p>Have used words as they have learned them, without generalising them (Vol 8)</p> <p>Poorer when younger at naming either children / people (Vol 8)</p> <p>Perhaps greater tendency to describe things by visual appearance (over function, purpose or meaning to other people) (Vol 8)</p>	<ul style="list-style-type: none"> <li>• Can be stuck in 'street' style of communication and doesn't know how to change register depending on audience.</li> </ul> <p>May have vocabulary related to people (Vol 8)</p> <p>Might be more able to discuss / see things in terms of who owns / uses them (Vol 8)</p>
	5.5 language (Vol 2)	<p>Specific uses of language, odd terminology, miscategorising, idiosyncratic uses of language, accents – (including American) (Vol 2)</p> <p>Mismatch between receptive and expressive skills, which can give a misleading impression of verbal abilities, particularly misleading when using sophisticated vocabulary related to their interests (R)</p> <p>Understanding and use of language issues could be present in ASD because the child has SCI deficits that would be apparent irrespective of care received (Vol 7)</p>	<p>Delayed language, (poor narrative coherence) (Vol 2)</p> <p>Understanding and use of language issues could be present in attachment because of a lack of language rich environment (Vol 7)</p>
	5.6 Commenting	<ul style="list-style-type: none"> <li>• Provides detail in pedantic fashion and gives excessive information</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced amount of commenting behaviour</li> </ul>

## 6. Emotional regulation

Although the behaviour may be similar, the causes seem to be different. **A different causal relationship between anxiety and behaviour/ preferences (R).**

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
<b>6. Emotional regulation</b>	6.1 Difficulties managing own emotions and appreciating how other people manage theirs	<p>Extremes of emotion may provoke anxiety and repetitive questioning and behaviour</p> <ul style="list-style-type: none"> <li>• Does not easily learn management of emotions from modelling (also likely to need an explanation)</li> <li>• Poor recognition of emotions</li> <li>• Emotions take over from logic/knowledge of what one should do (e.g. when losing a game)</li> <li>• Does not show displays of emotion to everyone – discriminating between people and places (e.g. never has a temper tantrum in school)</li> <li>• Difficulties showing empathy even for significant others in life</li> <li>• <b>Empathy is more likely to be cognitive, although cognitive empathy (may still be) is poor. Cognitive empathy may be arrived at through a logical problem solving process and does not come intuitively (R)</b></li> </ul> <p>Social and interaction difficulties evident regardless of 'mood' (R)</p>	<ul style="list-style-type: none"> <li>• Difficulty coping with extremes of emotion and recovering from them (e.g. excitement, fear, anger, sadness)</li> <li>• May provoke extreme emotional reactions in others which tend to cast others in roles which are familiar from their own past experience of less healthy relationships</li> <li>• May be able to learn more easily from a nonverbal example than from talking</li> <li>• Shows emotional displays to people child does not know (indiscriminate) and tends to carry on longer (e.g. temper tantrums occur anywhere and at any time)</li> <li>• Difficulties showing empathy in general but can show better empathy towards a significant other</li> <li>• Highly tuned to non-verbal aspects of emotions</li> </ul> <p><b>Social interaction and other difficulties may not be as evident when anxiety is absent so anxiety is seen as an underlying source of observable manifestations. Anxiety creates the need for predictability (what's coming next,</b></p>

	6.2 emotional investment (Vol 2)	<p>Individuals have a propensity for sameness / routine and anxiety is aroused when this is disrupted (R)</p> <p>More easy to establish triggers in ASD (to an emotional incident) (Vol 2)</p>	<p>preparation for transitions – rigidity was about control and managing anxiety). When calm (not highly distressed) could hold a conversation, didn't want to talk about his own interests all the time, was able to apply learning to different contexts, appropriate interaction when calm, he wanted friends (Vol 3)</p> <p>Highly anxious individuals impose routine / order to try to exert / gain control for the management of anxiety (R)</p> <p>Emotions triggered perhaps by things that relate to their experiences and therefore seem unpredictable (or unobservable / fathomable) (Vol 2)</p>
	6.2 Overload (Vol 8)	<p>'Meltdowns' have more predictability. Within school reactions are often to shut down / switch off (more likely to go into catatonia as per the rules of not shouting, kicking etc.) and acting out more likely to happen at home. At home may be more likely to self-harm and / or adopt foetal position / enjoy 'cuddles' to soothe and relax/ retreat (Vol 8)</p> <p>'Meltdowns' are not towards people in an abusive way and 'Losing it' can appear 'incoherent' or nonsensical (Vol 8)</p>	<p>'Meltdowns' may appear less predictable and can 'go off pop' anywhere / everywhere Meltdowns can be dramatic and directed at others Can have a shock factor of drama / trashing / screaming (Vol 8)</p> <p>Can give appearance of 'watching' for social impact and more likely be personally abusive</p>
	6.3 Unusual mood patterns	<ul style="list-style-type: none"> <li>• Sudden mood changes in response to perceived injustice</li> </ul>	<ul style="list-style-type: none"> <li>• Sudden mood changes related to internal states (e.g. to PTSD, flashbacks) and perceived emotional demands</li> </ul>
	6.3 Inclined to panic	<ul style="list-style-type: none"> <li>• Panics about change in routines and rituals and about unexpected and novel experiences</li> </ul>	<ul style="list-style-type: none"> <li>• Panic related to not having perceived needs met (especially food, drink, comfort, attention)</li> </ul>
	6.4 Expectations of change in	<p>Wouldn't expect to see such a rapid change. Would expect to see a reduction in anxiety in more responsive hands, and</p>	<p>A rapid change in emotional presentation when care circumstances change.</p>

	emotional presentation when care circumstances change (Vol 8)	get more 'looks' but not big beams / smiles/waves (Vol 8) – qualitative change in presentation after removed from home	Also how the change in social overtures 'felt to her' to observe / be part of. Increased referencing to others with eye gaze and child being able to be 'back in the normal group' with the 'normal' support (Vol 8)
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7. Executive function – both may have difficulties with attention control (Vol 7) Both may find it hard to sequence, organise, generalise (Vol 8) waiting can be hard for both groups (Vol 8)

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
<b>7. Problems with executive function</b>	7.1 Unusual memory	<ul style="list-style-type: none"> <li>• Poor short term memory unless well-motivated</li> <li>• Very good long-term memory with recall of excessive detail for areas of particular interest to the child</li> </ul> <p>Detailed or over detailed, may include information about 'things' (like what you had on, the colour of the gate at the holiday resort) (Vol 8)</p> <p>Often not shared until cued in i.e. not in general conversation (Vol 8)</p> <p>Memories are generally not people related, more akin to a photo / snapshot or video – copies lying dormant (like videos in the loft) (Vol 8)</p> <p>Memories may not be processed / grouped / integrated with other similar (Vol 8)</p> <p>Content may be more visual memories of places / events and have specific detail (Vol 8)</p> <p>More likely to recall accuracy / specificity (Vol 8)</p>	<ul style="list-style-type: none"> <li>• Fixated on certain events</li> <li>• Recall may be confused</li> <li>• Selective recall</li> </ul> <p>Memories may be more impressionistic, a sense of an event, rather than the detail of an event</p> <p>Memories maybe more confused and trigger huge emotional reactions when current environment make links with previous experiences (Vol 8)</p> <p>Content maybe more to do with people and emotions (you were angry, you said this)</p> <p>More likely to get false recall or be more confused</p>

		May include details so minute that others didn't register the same detail, as to them it was irrelevant (scampi was off the menu that day when we went to Whitby) (Vol 8)	
	7.2 Affinity with pattern (Vol 8)	A pattern seeker (Vol 8)  (Would this suggest an element of hardwiring / propensity to seek pattern?) Patterns help them predict so sequencing is the pattern	Perhaps through exposure to chaotic environment (Vol 8) (Would this suggest these skills are learned through social engagement rather than hard wired?)
	7.2 Difficulty with concept of time – limited intuitive sense of time	<ul style="list-style-type: none"> <li>• Rigid reliance on the using precise times (e.g. uses watch and unable to guess the time)</li> <li>• Waiting irritates child because it affects routine</li> </ul> <p>Waiting is difficult because you don't understand what waiting is – you are expecting something to happen next, and 'waiting' constitutes the pattern going wrong (when waiting is incidental / accidental e.g. the doctor / bus is running late) (Vol 8)</p>	<ul style="list-style-type: none"> <li>• Time has emotional significance (e.g. waiting a long time for dinner is quickly associated with feeling of emotional neglect and rejection)</li> </ul> <p>The triggers might not be related to patterns going wrong – they may be triggered more emotionally. Waiting for 'x' (person or food) signals that your needs might not be met (Vol 8)</p>
	7.3 Poor central coherence	<ul style="list-style-type: none"> <li>• Inclined to consider the immediate context (not taking into account past experiences and emotional factors)</li> </ul>	<ul style="list-style-type: none"> <li>• Emotional bias leads to ignoring some elements of a situation (attention drawn to elements with emotional significance)</li> </ul>
	7.4 Attention control (Vol 7)	Attentional difficulties may be less apparent when focusing on their specialist interest or on their chosen activities. At other times, attention control can be focused on small parts of an activity (at the expense of being able to see the bigger picture) but may also give the appearance of attention being very permeable, as if unable to sort the wheat from the chaff and thus focus on important / salient features to the task in hand (and screening out irrelevant stimuli) (R)	Difficulties paying attention due to 'hypervigilance' and being 'on guard' against danger (R)

8. Sensory processing **Sensory seeking / sensory avoidant could be in both (Vol 2)**

Symptoms of ASD	Problems seen in both ASD & AD	Typical presentation in Autistic Spectrum Disorder	Disorder Typical presentation in Attachment Problems
<b>8. Problems with sensory processing</b>	8.1 Difficulty integrating information from senses (e.g. lack of awareness of heat, cold, pain, thirst, hunger, need to urinate/defecate) and lack of physical problem solving skills (e.g. removing coat when hot)	<ul style="list-style-type: none"> <li>• May be passive and quiet in acceptance of discomfort or may be distressed but does not communicate the source of distress</li> <li>• May be hypersensitive to some light sensations even when pain threshold is high (e.g. labels in clothes irritate but a bitten arm does not)</li> </ul> <p><b>Maybe more unusual in terms of mixed profile and sources of stimulation – perhaps more stimulating and exciting seeking feedback</b>  <b>Perhaps more visual / auditory issues re sensitivity (Vol 2)</b></p>	<ul style="list-style-type: none"> <li>• Physical discomfort may be accompanied by a strong emotional reaction towards carer (e.g. anger and blame of carer for the discomfort)</li> <li>• Discomfort from basic needs may not be reported to carer (e.g. hunger, thirst) until they are intense</li> <li>• Discomfort connected with physical needs may quickly provoke irritability and distress and provoke the carer to work out and solve the problems for/with the child</li> </ul> <p><b>Sensory behaviour maybe more linked to an emotional comfort</b></p> <p><b>Senses may trigger emotional memories / have emotional connections (Vol 2)</b></p>
	8.2 Unusual physical proximity	<ul style="list-style-type: none"> <li>• Physical distance is unrelated to intimacy (e.g. they stand too close because they are unaware of social proximity rules)</li> </ul>	<ul style="list-style-type: none"> <li>• Shows awareness that physical closeness is related to emotional reactions (e.g. increases distance to signify rejection; seeks excessive closeness when anticipating separation)</li> </ul>
	8.3 Self-stimulation	<ul style="list-style-type: none"> <li>• Self-stimulation is likely to be related to own sensory needs</li> </ul>	<ul style="list-style-type: none"> <li>• May show sexualised behaviour or present in a sexual way to provoke reactions or to self soothe.</li> <li>• Self-harm is connected with emotional state</li> </ul>
<b>Other</b>	<b>9.1 parental</b>	<b>Parents in both cases can find behaviour difficult to</b>	<b>Perhaps more typical that a parent might report that they</b>

	reactions (Vol 3)	manage. Typical that parents report that they can “manage him / her by / if / when they....” (Vol 3) (perhaps linked to the more identifiable patterns / triggers) (R)	“can’t manage him / her...” (Vol 3) (perhaps linked to a less identifiable pattern or as an indicator of parents attachment pattern) (R)
	9.2 Parental presentation (Vol 3)	EP’s interpretation / observation of mum’s presentation (Highly anxious) – family matters / relations. EP’s view of mum versus other mums of children with ASD. ‘Can manage him by / if we / when we (‘adapt’ things)... (typical of parents of children with ASD) (Vol 3)	versus ‘I can’t manage him’ (more typical when issues are relational / attachment based) (Vol 3) Word used in talk to describe impression of mum include ‘anxious’ ‘passive’ / ‘denial’ and ‘avoid’, all of which could be linked with attachment theory (R)
	9.3 parental interactions (Vol 3)	Parents’ presentation and their interactional dynamics could be included in the problem analysis / hypothesis generation as sources of information (Vol 3)	
	9.4 Assessment suggestions (Vol 8)	Parental recollections of typical early development followed by a change at a point in time  A constellation of observable features in the absence of other explanations i.e. no obvious trauma, no major illnesses, no terrible event  Balancing out the strength of information from a good period of structured intervention which has not resolved difficulties (Vol 8)	Behaviours / responses noticed during a home visit would include: The child’s curiosity / exploration The child’s anxiety Who the child seeks permission (to play/explore) or comfort from Does child seem to expect a response from parent How reassuring / responsive are parents (do they break off talk to help): are they warm, nurturing and encouraging (Vol 8)

Moran (2015) clearly sets out the boundaries of the Revised Coventry Grid,

“The Grid is particularly thinking about children with ability in the mild learning disability to above average range and those who are interested in connecting with people. It is less useful for the more severe learning disability range and those children who are withdrawn and very avoidant of social contact” (p1).

Volunteers in this study have drawn on a range of experience in their talk, which is not limited to a particular ability range or propensity for social connection. This could mean that suggestions from the current study are considered a distraction from the specific purposes of the Coventry Grid and therefore not suitable for inclusion.

Volunteer 2 made some specific comments about the usefulness of the existing Coventry Grid, in her view, Interview 1, beginning at line 85

Line 85: how, in what way does that research question resonate with you in your experience? Erm a *lot really* because I think it's something that comes up *incredibly* [laughs] frequently [laughs] Right Yeah. So yes, I've often had to, had my Cambridge [pause] thingy, whatever it's called, Er questions. I don't know. You know the one I mean. I managed to get it out before, I [unable to hear 05:05 shuffling papers] what's it called. *That's the one, the Coventry Grid, you see, Ah losing power, power of language.* Is it down that way? [both laugh] Yes, down to Coventry, gone to Coventry. Yes, erm I frequently referred to that, I'm not sure I've always found it very *helpful*, Hmm but it's an interesting framework. Maybe we can come back to that, Hmm then, in a bit?

And again in Interview 2, beginning at line 52,

Line 52: Okay. Erm so we talked about, you talked about the Coventry grid...*Yeah....*and you, my impression was that you had a mixed view of it...*Yeah, yeah.* And I wondered if you could say a bit more about your mixed view. Right, [pause] er it's interesting when you look at, you know, for example, something like play from an attachment and autism point of view, but the Coventry grid gives more reasons rather than, there's very *little difference* in observations, I felt. It kind of gives different *explanations* Yeah for why people behave, but it's not a, it will be very nice, I know it's not possible, but it would be very nice if it was a sort of a pick it up, in a checklist of if he does that, he's autistic and if he does that Yeah it's attachment. But it's not actually like that, it's, erm it will say something like, the both had difficulty in play situ... play situations with other children, and why that's true for the autistic child and why it's true for the child with attachment difficulties. So, yes, it's interesting to think, it gives you a *useful* framework to *think about*, erm but it doesn't give you the solutions, erm and I tend to feel that, you know, it's kind of just giving you additional, it's giving you additional evidence, but it isn't really, well, the kid with autism does that Yeah and the kid with attachment does that. It's well they both do that but these are the different reasons behind it, and what *you see*, the differences would be very, very subtle. So it's just, it's part of accumulation of evidence really. I suppose I can only



say that whenever I've looked at it, and I have *often* looked at it, it hasn't given me any 'ah ha!' insight [laughs] in decision making, Right but, I mean, that's, you know, it's naïve to expect it to really. So two words that you used were *interesting* and *helpful*, so is the interesting bit about the framework to think about, but the the limited helpfulness, because it doesn't give solutions, so you use two words, interest, sort of theoretically...**Yeah, yeah, it is interesting, it's *definitely interesting*, because it's looking at behaviour and giving it two different perspectives.** Yeah. Erm but in terms of, you know, scores, it's not a score on the door, so many points, [unable to hear 0:04:40] Yeah it's just not like that, and not intended to be obviously. So...[pause] What *does* it intend to be then, why has she made it..., I can't remember what she...? [Laughs] Erm I suppose it's giving different perspectives on a piece of behaviour, isn't it, it's looking at a piece of behaviour through two different erm [pause] possible hypotheses, [pause] and an attempt to disentangle. [pause] An honest attempt, I'd say. Hmm but when you actually look through it, there's very little that's *ah ha!* in the ASD column and not in the attachment and vice versa, it's just different interpretations. Interesting that you added the word *honest*. **Yeah.** I've got there. **Okay.**

My understanding of the Coventry Grid, is that it offers a combination of similarities, differences and underlying explanations. The suggested value added by observations and reflections from volunteers in this study is that firstly, that existing similarities, differences and explanations are elaborated. EPs' accounts were woven into a number of domains, so that existing ideas were embellished and new areas are offered for inclusion. The latter, for example included, stealing, interactions with unfamiliar adults, language, emotional investment, overload, expected response to change in care circumstances, affinity with pattern, attention control, parental reactions and presentation, history taking and assessment suggestions. Secondly, two further additions (how it might feel as an adult conversational partner to these two groups of children and suggestions as to how the information in the Grid is to be used) added a different perspective. In other words, the focus within the existing Coventry Grid is on the child's behaviour, and the suggested additions of this study include consideration of impact of the child on the parents and on the professional(s) involved.

The talk that I wove into the Coventry Grid came from all but Volunteer 5. The talk of Volunteer 1 offered one example (about flexible thinking) and the talk of Volunteer 8 provided a large proportion of the material. I offer interpretations of these observations.

Volunteers in this study who made the majority of potential contributions to the picture of overlapping phenomenology were those EPs whose accounts of practice indicated some level of ease working within the strengths and deficits of categorical dimensions, perhaps reflecting an essentialist position (a diagnosis means 'you have it'). In contrast, those whose talk did not inform the potential overlapping phenomenology (Volunteer 5 in particular, and to some degree Volunteer 7), articulated a preferred use of a strengths based approach, did not value place significant value on diagnosis and 'categorisation' and preferred to work from perspectives that reframed narratives that had developed around children or that focused on how to best support their presenting needs. Findings of research questions 1 and 2 have already highlighted that my interpretation of Volunteer 5's talk about practice and conceptualisations has positioned her somewhat differently to the other volunteers. The relative absence of talk on this research question by Volunteer 1 (who has considerable experience of undertaking autism related assessments) was explored, however, as striking. My interpretation is that her interviews instead, included more extensive coverage of other topics of talk (how she conceptualises autism and attachment difficulties, her practice of problem analysis and how she conceptualises the value of the contribution of EPs in this area of work).

A substantial number of the threads woven in to the Coventry Grid were extracted from the account provided by Volunteer 8. In between her first and second interviews, Volunteer 8 compiled a document of notes about overlapping phenomenology. She did this through an exercise comparing a particular child with peers in the same 'educational unit' to clarify her thoughts about what 'strikes her as different' [between him and them]. Engaging in that process enabled her to also broaden her reflection to include other children she has experienced. In producing her document, she began by listing 'what' might be different, then tried to think of 'how' they might be different. A large proportion of her 2<sup>nd</sup> interview was used to discuss that piece of work. Her professional position was as the most experienced volunteer, by definition of years of post- qualification practice and the

specific work related autism related roles she had performed. Jordan (2015) emphasises that diagnosis continues to require clinical judgement about the psychological processes that underlie presenting behaviours and brings to the fore the idea that behaviours can have a different meaning when interpreted through the lens of autism,

“...it remains true that the defining feature of autism is that those on the autism spectrum lack instinctive social understanding, not finding social signals salient, and thus having to learn cognitively (and be so taught explicitly) all the things that others just acquire naturally”...(p86)

This might seem to suggest that harnessing further clinical experience to enhance the functionality of the Coventry Grid would be a worthwhile endeavour. In introducing the revised the Coventry Grid (The Coventry Grid Version 2), Moran (January 2015) describes that,

“The Coventry Grid is an attempt to summarise the differences between the behaviour of children with Autistic Spectrum Disorder and those with significant attachment problems. It is based upon clinical work with children rather than research” (p1).

The original version of the Coventry Grid was added to by a London/South of England group of speech & language therapists who work in youth justice and after discussions with professionals at CPD sessions about particular parts of the grid. Moran (2015) highlights that there were no major revisions but descriptors were added to some sections and there were some small changes to descriptors. Moran does not state why Speech and Language Therapists working in a particular region and service area were involved in the revision exercise or which professionals were involved in the CPD session.

The current study is similar in that it also draws on the clinical experience of practitioners rather than on findings from ‘research’. I posit that the volunteers in the current study have pertinent professional standing that their contributions are seen as worthwhile. The volunteers have a combined EP experience of over ninety years. Post qualification they have worked as EPs across six Local Authorities in the North of England. Five have experience of contributing to local multi-agency diagnostic assessments for autism, and one has taken a lead role at diagnostic discussions. They

have occupied positions of main grade, senior practitioner and specialist senior (ASD) roles. The second part of this research question, outlining the talk around problem analysis processes, and the final section which discusses the skill set available to the discipline of Educational Psychology, I suggest, strengthens the view that volunteers' contributions to the Grid are suitably informed. Moran's Coventry Grid captures a rich clinical experience base, and the volunteers in this study likewise draw on considerable relevant experience, which without having taken part in this research process would lie within individual pockets of understanding.

Writing about evidence based practice in relation to EPs, Lloyd Bennett (2016) notes, "the variables which influence published research are potentially limitless and a considerable amount of work is needed before concepts become accepted as 'evidence based'" (p21) and asks what of an individual's combined experience is sufficient evidence base to inform practice? In considering how and whether rich clinical experience 'in the field' becomes 'accepted' by the clinical community, according to Fish (1985), one needs to consider the emergence of research as situated within socio-historical and cultural conditions and the wider societal issues that come into play in explaining popularity or acceptance within a research community. The research community does not exist in a vacuum but is socially and historically located. Fish's (1985) paper on anti-professionalism asserts that,

"needs and values does not exist independently of socially organised activities but emerges simultaneously with institutional and conventional structures within which they are intelligible" (p101) and that the research community "are custodians not of an essence but 'of a discourse' and their task is to preserve this discourse, extend and elaborate it as necessary, defend it from other forms of discourse, initiate newcomers into it and determine whether or not they have successfully mastered it...what become features of the landscape are products of the institutional and professional forces" (p102).

Moran's Coventry Grid (2015) is not cited in the Appendix K (supporting differential diagnosis) of the NICE Guidelines (2011), which could be inferred as a sign of acceptance. Similarly, Crittenden's clinical and cross cultural case work 'in the field' receives only one line of mention in Prior and Glaser's (2006) book detailing the historical development of attachment theory and, like Moran, is

not cited in the NICE (2015) Guidelines relating to attachment in children and young people. Practice is considered to be research by some (for example, Parker 2013 and BPS 2010) but perhaps the wider research community 'as custodians' (after Fish 1985) perceive findings of clinical work less acceptable pathways to knowledge than the currently predominating 'gold standard' positivist research methodologies (Molloy et al 2002), and, 'outsider' research methodologies and settings, positions the findings of 'field research' at a tangent to Fish's (1985) "institutional structures and professional forces".

#### 7.4.2 Research question 3b. How do EPs conceptualise their problem analysis processes?

The combined thematic extracts from individual volunteers relating to this question are provided in Appendix N.

The previous section presented ideas expressed in the talk of volunteer EPs about overlapping phenomenology. Unlike the methodology of the production of Version 1 and 2 of the Coventry Grid, talk about overlapping phenomenology in this study was contextualised as it was generated through the course of individual iterative interview cycles, interviews which also discussed practical and theoretical aspects of EP problem analysis. This second section addressing research question 3, presents how, through what kind of process, EPs report that they actively attempt to differentiate between autism and attachment when they construe this activity to be of value.

It is appropriate, first, to note the contexts on which volunteers were drawing. Volunteers had been asked whether they would find it most helpful, for them, to think of specific casework examples, or to reflect on their practice in more general terms. Volunteers 1, 2, and 8 elected to draw on a range of experiences and so chose to speak of their practice in this area in a general way. Volunteers 3 and 7 spoke to specific casework examples. Both had chosen to focus on specific casework examples and use involvement in the research as an opportunity to process the complexity encountered; one was a very recent casework example she had not had 'chance to process', the other was an ongoing involvement that was perceived as particularly challenging. Volunteer 5, like volunteers 1, 2 and 8, spoke about her practice in general terms, and with some points of similarity of process to other volunteers but the reader is reminded, as noted in an earlier section, that she reported she does not engage in activity discerning attachment and autism.

As a way of introduction, Figure 5 provides a visual representation summarising my synthesis of EP talk to be discussed in this section addressing problem analysis processes. The words used in this figure are taken from the talk of EPs (Appendix N).

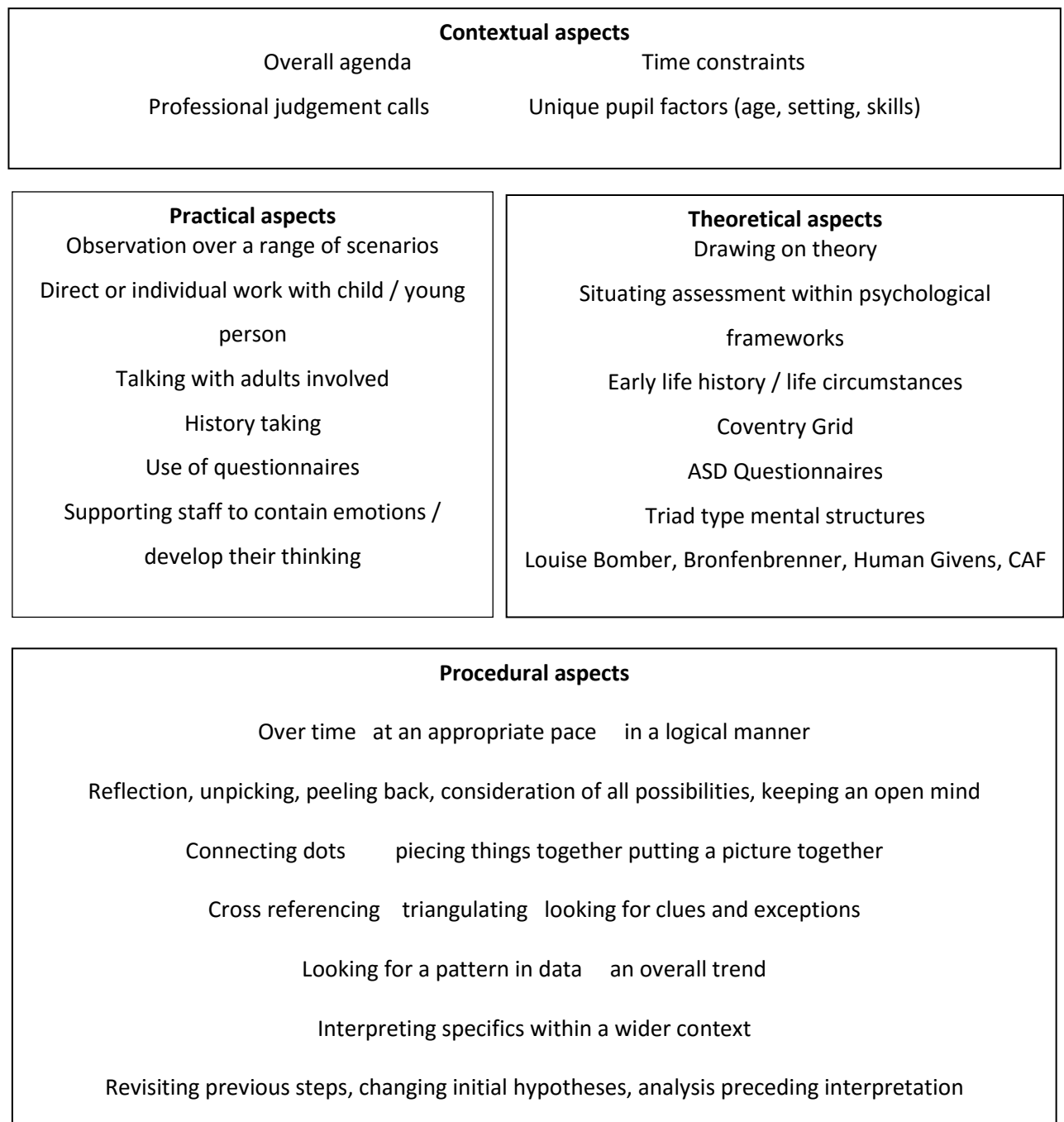


Figure 5. My figurative summary representation of EP talk addressing problem analysis processes.

This summary representation using terminology extracted from the cross-case analysis is chosen as a way of more effectively conveying the nature of talk during interview discussions. Mindful of this

reduction, and my imposed system of organisation, what follows is an honest attempt at describing the talk of volunteers across interviews. Presented here as discrete sections for ease of discussion, problem analysis as discussed in this study is better held in mind as tasks and the activities being intertwined with processes of interpretation and hypothesis generation, the exact nature of which is influenced by unique contextual circumstances. Problem analysis processes were not expressed as a one size fits all phenomena.

### Contextual aspects

Some volunteers spoke of how contextual or pragmatic factors can determine the exact nature of the activity they undertake. For example, Volunteer 1 spoke about the overall agenda behind a piece of casework (who had requested it and why) as influencing choices she made about activities to undertake. Volunteer 7 spoke of about how changes in her role were actively chosen by her through the exercise of professional discernment and autonomy (professional judgement calls), determining the most appropriate contribution from her (in the child's best interests) as circumstances changed within her casework example. Volunteers 1 and 2 also spoke about time constraints (what's the job? How long have I got?), which were expressed as perhaps more pressing in a traded services context, where negotiation about the details of involvement was expressed as more challenging (compared with when time 'belonged' to the local authority. Volunteer 2, Interview 2, beginning at line 178,

Line 178: I wondered if, maybe, you had a consultation that looked a bit like one thing and then, depending on what came out of it, then you had [pause] a *different* type of *conversation* with them or...? **Again, it depends on the agenda of what I'm doing, which would rarely be just to see if a kid had autism or attachment, it doesn't, the consultation would follow, would start with what the problem, Yeah with problem solving, and if I had in my head, you know, "Was this autism or attachment?", I might then explore the family situation, whereas in other contexts I might not. Yeah. [long pause] I suppose it's just how it fits Yeah into the bigger picture of what I'm doing, and also what is *the overall agenda* of what I'm there for on that day, you know, that I've got to actually achieve, you know, [pause] and whether I'm likely to be able to *come back* and, you know, *how much follow up* there's going to be, and all of that's affected by *time constraints* and how much the school's paid and, Yeah you know, there's all sorts of factors, isn't there, on *how big a job* you're going to do on it. [pause] Do you think it affects sort of *depth*, then, *depth* of**



work? **What, the time constraints? Obviously.** Well, time and who's paid for what and... **Oh God, yeah, yeah, it must do, mustn't it.** Well, yeah. Does that ever pose a particular difficulty in terms of, I don't know, [pause] I suppose the ethical side in terms of...? **Yeah, course it does.** Hmm **Well, loads of things do, don't they?**

Volunteer 7 spoke of the tension created or the challenge posed by preferring herself to work at a pace that she judges appropriate for due process, whilst working in a context where other professionals (non-psychologists) are pressing her, wanting a result. Volunteer 7, Interview 1, beginning at line 493,

**Line 493: would have been hard. Er and, possibly, other people's expectations in the frameworks, maybe, might have, they're kind, other people's ideas are there, aren't they? Yeah Are you looking to prove or disprove *that*, Hmm or does that stop you from *just* wondering and being curious when you've got all these people waiting for the answer, Hmm I suppose, that you're trying, maybe, *resist* a bit and just, er, be a little bit more open to exploring.**

The time pressure is implied here by people waiting whilst she wants to be more open to exploring. Individual child characteristics such as age of child and skills were also reported as influencing the planning of the specific assessment activities (Volunteer 1). Professional judgement calls (have seen what I need to see in 20 minutes of observation?) (Volunteer 2) also influence the precise detail of what might be undertaken in a particular situation.

#### Practical aspects

Volunteer 1 expressed a preferred order for conducting these kinds of activity summarised in Figure 5 (e.g. completing observational work before direct work) as did Volunteer 2 (observing a child or young person before consulting others). Some volunteers indicated that whilst assessment is underway, context may also mean that they engage in other activities at the same time. Examples were of supporting staff with strategies and the development of their thinking (Volunteer 1) and containing the emotions of staff (Volunteer 7).

These activities and tasks were expressed as applied with creativity and fluidity, rather than as a set of circumscribed tools and tasks applied in predetermined way irrespective of context and individual factors. This is somewhat different in approach to the algorithm of the autism assessment pathway that has been implemented in the region. In that pathway, the same standardised cognitive assessment (the Wechsler Abbreviated Intelligence Scale Children IV UK, 2004) and a number of questionnaires are prescribed parts of the pathway.

### Theoretical aspects

In discussing the theory that EPs drew on, Volunteer 1 spoke of applying a systemic approach supported by frameworks such as the Common Assessment Framework (2004) and Bronfenbrenner's ecological model (Bronfenbrenner 1979). She also spoke of the Human Givens perspective (Griffin and Tyrell 2013) as a framework that she found helped her consider the ways in which a child's basic emotional / psychological needs were being met or could be contributing to their presentation. She talked of engaging with this kind of thinking before searching for diagnostic type explanations.

A number of Volunteers (1, 2, 3 and 8) spoke of the use of 'triad type' mental structures to gather, collate and begin to evaluate information. Information about life circumstances was referred to as being sought by some (Volunteer 1, 2, 7, 8), and in particular looking for early life history for clues / pointers (Volunteer 1) and the way parents present and interact with the child in question (Volunteers 7 and 8). Two volunteers (1 and 2) referred to the use of Coventry Grid (Moran 2010/2015). Volunteer 2 referred to often having referred to it for interest and Volunteer 1 who used it to 'map out' information and spoke of using it in a dialogic manner with parents. Reference was made to the use of specific tools (a 'text by Louise Bomber', ASD questionnaires, neither tool specified further). Volunteer 3 spoke explicitly about different types of information gaining approaches within her approach: 'gleaning' (incidental learning or information that presented that

had not been solicited), 'gathering' (specifically solicited information) and 'observing' (directly experienced sources of information).

### Procedural aspects

The bottom part of Figure 5 encapsulates the talk of Volunteers that I have grouped as references to process. EPs spoke of engaging in an assessment process over time that was conducted at an appropriate pace. Volunteers spoke of the process as one of extensive information gathering, comprehensive cross referencing and triangulation with those that know the child well. Phrases used to describe the analytic and interpretive processes were: unpicking, peeling back, piecing together, connecting dots, looking for a pattern in the data, looking at the whole, an overall trend, putting a picture together, and interpreting specifics in the wider context of overall picture. The information gathering and interpretative processes were expressed as iterative processes where previous steps could be revisited and where the mind was open to looking for consistencies and exceptions. Emerging or initial hypotheses were seen as subject to change, with analysis preceding interpretation so as to avoid premature decision making. Volunteer 5 spoke of being logical in her approach, in the sense of being methodical and being able to justify steps taken and interpretations made (as opposed to following a planned sequence of steps). Reflection and consideration of all possibilities were highlighted. Synthesis, as expressed as interpretation and hypothesis generation, involved looking for the spread of evidence across the triad, what is there as well as what is not there, rather than specific features falling readily into one camp or another (Volunteer 2, 3 and 8) and information being considered in the context of other things seen / known (Volunteer 1).

Volunteer 2, Interview 1, beginning at line 308 and picked up again at line 629

I'm wondering if we're getting [pause] the *themes* on, or there's *strands* in which [pause] you would conceptualise *both*, **Hmm** or you would explore both, but telling telling the differences about qualitative interpretation or...? **Yeah, and it's looking at a *pattern*, isn't it, it's looking at *all of these* things together and not just one. I mean, it might be *extremely* difficult to tell erm in terms of flexibility whether it's one or the other, but you'd be looking at the whole, you'd be putting a picture together. But *I am always wary* you can't,**

you know, being one doesn't exclude, can't necessarily,

Having said that, I can think of kids who, I've *no doubt whatsoever*, were autistic, without *any*, one has *sprung into my mind* that just [laughs] yeah, *wouldn't have been any question whatsoever* [laughs]. So, in that particular situation, Hmm what swung it, what was the what was the *obvious*...? Right, this was a girl in [name] secondary school [laughs] who came and sat right next to me *at break*, and said, "I'm reading this book, would you like me to read it to you?", and then proceeded to do so [laughs]. Now, in a very sort of strange, [both laugh] slightly American accent [both laugh] I seem to remember... I was maybe thinking to ask, to explore with you, [name], of why you maybe swung for the, maybe a lack of appreciation Mmm for social convention and an awareness of your needs, versus social inhibition Mmm that might be more of the attachment description. Right, yeah. But you threw me with the American accent [laughs]. Yes it was completely [laughs] yeah. That's not in the Coventry Grid, is it [laughs]. No [laughs]. Erm [coughs] We could add it to your description of language. Hmm, yeah, well, I did say idiosyncratic. Yes, you did. Sort of speech and language and, yes, speaking in strange accents is definitely

Volunteer 3, Interview 2, beginning at line 701

"Right, okay, so how does this fit in with that?", and I do often think it's about a best fit in these situations. If it's a best fit, is there an element of weighing up and a compromise, as in not black and white? I wouldn't call it a compromise. I think, children very, none of us fit into direct compartments in anything, I don't think, so you're never going to get someone who just fits perfectly into one particular compartment. Hmm So, when I say best fit, that could sound like second best, but I don't think it is. Yeah, not to be confused with, yeah? Yeah, it's not second best, it's *about*, but also it's that, to get that, it's not just, it's looking at that whole story, so it is, it's looking at *all* aspects, so what is going on with family, what is going on in the environment, what is, which is what we do *anyway* as EPs. But, I think, particularly in these cases, when it's not, when it doesn't feel straightforward, you *really do* have to get all that extra information, I think, because it's part of that. So, "This is happening, why might that be happening? Well, we heard this, we heard that, could that have a bearing on why he's doing that? But then the mother's saying that, so could that be...?", etc, and take time, I think, on these, *take time*, because they're not. When you said in this, are you searching, you would do all these things anyway, but in these particular situations, *especially*, you need to get *all this extra information*, does it mean there's something that's *more at stake* in these situations or that requires exceptional processing or...? Well, because in these situations there's no, there's no standardised test you can give, that's the first thing. So you're doing it *purely* on behaviours, what you're seeing in front of you, for both of them, aren't you. Yeah So *therefore* you have to, you need all the, yeah, I think that's why you need more, because you can't test for anything. No blood tests? No No, no literacy tests, no [laughs] etc. So, and as I say, that's often what you do anyway as an EP. But, I think, for these, particularly with the attachment stuff there's so much bound up with family and home situation that you have to have some knowledge around that, much more so than other situations, to find out what, because that's an important, such an important.

Given these descriptions of practice, and bearing in mind that Volunteer 2 had commented that she did not know how to use the Coventry Grid (Moran 2015), I propose that, it is at this point of synthesis in the casework stages of EP problem analysis, that the Coventry Grid could be used as a tool to support hypothesis generation.

In this study, EPs' talk did not explicitly refer to the use of particular problem analysis frameworks or approaches but I considered did resonate with the identification of problem dimensions of Monsen et al's PAF (1998), perhaps most closely with steps 1-5. Volunteer 3 spoke of testing various ideas in a logical manner, with reflection and interpretation / consideration of all possibilities as part of a process rather than coming to conclusions soon. Volunteer 3, Interview 2, beginning at line 692,

**Line 692: "Well, I think I would encourage them to *reflect well*, because I think that is important. [pause] Take time to reflect on what, I mean, in some ways that's standard EP practice, isn't it, but I think I would *remind* people to do that, that, okay, "So look at what you, always take a very *logical* approach, which is, 'What are you seeing?', 'What is presented in front of you?', and then do that *process of*, so 'What *could* it be?". So, rather than jumping at something straight away, "What are *all the different things* it could be? Is it developmental?, Is it neurological? Is it environmental?, is it der, der, der, and if this is the behaviour we're seeing, what, *why* might we be seeing that behaviour, what could be underlying that?", and having *all* the possibilities, if you like, *and then* doing that whittling down in terms of, "Okay, then go back to some key information, text, whatever you like, to say, tools, to say, "Right, okay, so how does this fit in with that?", and I do often think it's about a best fit in these situations"**

My interpretation, having taken part in these interviews, was that we spent less time exploring the theoretical aspects drawn on during the problem analysis process, compared with the hypothesis-generation component of problem analysis. This could represent an artefact of my 'insider position', which might have encouraged assumptions of shared knowledge (problem analysis frameworks being 'taken as read') in our discussions. However, our talk also did not include any explicit references to using problem analysis frameworks (although I have suggested from my representation of EPs' accounts that parallels between those accounts and problem analysis frameworks can be inferred). This is perhaps noteworthy given the purposes of the frameworks presented in Chapter 4; Kelly (2008) proposed that a practice framework can be "conceptualised as a

structure involving a set of parts that sit or work together... a series of steps, stages, or actions that support the application of a theoretical model or models" (p18) *and enable practitioners to bridge the gap between theory and affective application of the theory in context (i.e. practice).*

I want to expand upon what might be implicit or explicit about practice by making connections between aspects of EP talk, the literature pertaining to role of problem analysis frameworks, and the status of clinical experience.

All the volunteers in this study were experienced EPs. Some had spoken of working on 'automatic pilot' (Volunteer 8) or working 'subconsciously' (Volunteer 5). Wick's (2013) discussion paper argues for EPs to continue to use executive frameworks throughout their practice in order to adhere to best practice guidelines – executive frameworks allow for transparency and accountability. She takes up the work of Kelly (2006) in suggesting why EPs understand frameworks in theory but do not use them in practice; 'marrying psychological theory with practice is hard work but also that professional experience might lead to processes becoming automatic or 'unconsciously competent' (EPs have frameworks in their head), so do not need to use them explicitly, but the use of frameworks would encourage 'reflective competence' instead. (p161). Annan et al (2013) similarly speak of the value of the continued explicit use of problem analysis frameworks by experienced EPs,

...."over time, as practitioners continue to use various guiding practice frameworks, these become automatic and internalised, and this is the level of "professional mastery" which should be aimed at (Wright et al 1995). There are some issues with this position. By explicitly adopting a problem solving framework, practitioners are supported in becoming transparent, methodical, analytical and accountable in the work they do and importantly in the quality of thinking that they engage in. Thinking is made explicit and thus open to inspection, validation and challenge. Adherence to explicit frameworks is not an indicator of a lack of experience or competency, but rather an approach which ensures intellectual rigour and accountability, and enables practitioners to be intentionally reflective... problem –analysis approach not only helped the various authors clarify their roles and their responsibilities, but also structured and made explicit their critical thinking as applied psychologists in increasingly complex working environments" (p91-92).

The most experienced Volunteers (5 and 8) in this study (by a considerable margin of years' experience) spoke of their practice being automatic and subconscious. However, through our discussions, I suggests we were able to some extent re-frame both of these positions, by making visible the clinical experience that lay behind espoused "hunches" and "conjectures" (volunteer 8) or by making explicit the theory behind espoused "subconscious" aspects of practice (Volunteer 5).

Volunteer 8, Interview 1, beginning at line 90

Line 90: you started to mention your identity in terms of what you've been practising in what kind of *roles* over the last **Uh huh** good number of years. **Yeah, twenty six.** [pause] Erm and I suppose I was wondering if, for me, this research process, you know, in the text books it's researcher, participant, **Uh huh** and very much a split between the job of *that person* and *that person* when they come together to *do* an interview, I wondered [pause] what thoughts you might have had about this being more of a peer collaboration rather than someone doing *something to* another person, because my *aim* is for us to be doing something together, *with each other*. **Right. Well, I think you probably know that my days of theory are, generally speaking, feel quite remote to me** Right so I would see this as a conversation. I've, erm surprised maybe how much I do, but I *don't consciously* ever, I *don't think as* consciously as perhaps some of the doctorate trained Yeah and readers think about *the theory*, in fact, even when you say social constructionism, it's only because my daughter's studying at the moment Yeah that I'm kind of aware of, "Oh, yeah, I do that". I do a lot of stuff a bit like, you know when you drive, you don't think, Yeah "Oh, I'm doing this", I do it. Er So if I was a bit more up on my theory, I would know whether that was subconsciously or...**[both laugh] Yeah, whichever or whatever.** It's not *unconsciously*, is it? **[laughs] No.**

Volunteer 8, Interview 2, beginning at line 569

Line 569: I don't know whether **[laughs]** you know, am I just kind of Yeah I don't know, that's where I wouldn't know, but I'm just kind of *conjecturing* Yeah that might be a difference.

Line 1000: and one of the questions [pause] I had, [pause] this was about what helps you when you've got this overlap, the muddy middle ground, what camp to put it in **Hmm** which we've just talked a lot **Yeah** about just there. But you you erm talked about *gut feeling*, and you've mentioned gut feeling tonight **Uh huh** so I'm just wondering if we can say a bit about where, because you've had a lot of qualifiers, you've mentioned the phrase 'gut feeling', and then said things like, "I don't know *if this is right*" **Yeah** which, [pause] I suppose I'm *wondering about the significance of gut feeling* and the role that it plays and should it be *down played or undervalued* or [pause] because it's, you've you've made *qualifiers* as if to say, "*This is not research based*", as if somehow if it *were*, it would be *more important*? **Or, just, I think, for some, what I could say is, gut feeling is, for some of the parallels that I've drawn, I could bring out and replay, "Oh, when we played this", or, "When we were doing that"** Hmm so some of them, obviously, because I haven't *been* having conversations, or I *don't have*, I haven't any *direct*, that's what I'm meaning, was that when I was doing those

Right comparisons, I just kind of [pause] could picture the, I've got *much more* experience of children who I think might have autism or Hmm have got a diagnosis *as a group* of, say, *literally hundreds more* than, it's *very rare* anybody comes out and goes, "Ooh! They've got attachment difficulties", and, again, it's, I suppose the boundaries for me is, are we looking at attachment difficulties *as in the normal population* Hmm with insecure attachments and what have you, *or* kind of more *significant* attachment difficulties, as in whatever type, D disorganised...So, although we might use the phrase 'gut feel', *if given the time*, you probably could *rework it, rethink it* and *then draw on* the nuggets of evidence that were there, which is what *informed* your gut Yeah what you've come to describe as gut feel? Yeah, I would think so. Erm and I'm thinking back to our conversation where you said, in twenty six years you *probably hadn't* Yes [both laugh] had the chance to sit down *and And, yes*. But now that you've done this enormous Mmm? fluid flurry Uh huh I wonder what, I mean, obviously it's kind of served a function for *this*, but I wonder what *other* purposes it might serve for you now, or is it just going to *go in the bin* for you or will you *keep it* or? This? I was just wondering about, yeah, its possibilities for you *beyond tonight*. [pause] I suppose, like a lot of things, it's just that it's there now in my mind, isn't it, it's that I feel...Is *all that* in your mind? [both laugh] Yeah, I've *formalised* some thinking, it's kind of like, *when would I need it*, Hmm *other than you asking me to formally draw upon it*. Yeah

Volunteer 8 considering her 'conscious' processing of a home visit, Interview 1, beginning at line 595

So to kind of try and set them *straightish* in their own heads as well as mine, is that we're just kind of meeting each other and getting a bit of background, and get an idea of what the child likes, you know, what toys they might have available Hmm all of that information that I suppose at some level is going in my head, although, I wouldn't say that I'd definitely got a mental checklist of, "I need to know this", but you can tell, you know, very tidy homes and more child friendly, [unable to hear 0:43:33]. Well, you know, for *most homes* with young children, I would expect to see toys out. Hmm Now, *yes*, you might be ushered into the smart room, but, out of *politeness*, but if the child's about, yeah. So that bit about, you know, and then their curiosity, do they unpack the back and this, that and the other, do they look for permission, who do they look for. So, *I guess, I'm building up without consciously* doing it, *some kind of attachmenty things* as to their reactions, do they hide behind the sofa, how anxious are they, how reassuring, although I can't say that I would ever, I don't think I've ever, it would have to be *fairly extreme* for me to think I need to do a lot more. Probably do perform more judgements than I'm conscious of. Hmm Probably do. I know for *some*, if parents, for example, are *warm* and nurturing and encouraging with the child, and that seems *natural*, you kind of cross that off your list, put it that way, so it's probably easier to say, *when you see that*, and it tends to get established fairly early, you think, right, okay, you know, if they break off the conversation, if they help the child fix a toy, if they *notice* they're getting upset, those sort of things. So if you *see* what looks like a, you know, fairly everyday nurturing, responsive Hmm interaction and a child who *does* appear to *expect* the parent to *do something* [laughs], you know, Yeah then I suppose that's one of the things I *might* cross off fairly early on, of the A) attachment list and B) opportunity. So I'm not sure I go in thinking that, attachment, I tend to go in thinking *opportunity*. Have they *had* [pause] *opportunities* to be *sociable*, *have they had opportunities for language, communication*, [pause] *fun* [staccato] [pause] So you're alluding there, we might say more at some point, about [pause] you think it's not got a mental checklist, but maybe if we were to chat more another time about...I *probably do, I probably do, I don't consciously feel* [unable to hear 0:45:53].



Somewhere in there after years and years and years of reading checklists and...**Yeah, yeah.** And I realise when I come back that I'm, yeah, quite *often* I come back, I just did an initial meeting last night, I'm off, like the first thing I, [pause] you know, one more or less said, well, discussed [unable to hear 0:46:12] with SENCO who'd met several times before, was, *was that typical* of a parent who *didn't seem remotely* concerned her child [pause] *isn't*, you know, is *way, way, way, way, way, way behind* and just socially unresponsive, everything. Didn't seem *remotely* bothered. Right. Just completely [pause] blank so I suppose you do... Is it tick some sort of box. It must do. Yeah It must do. But [unable to hear 0:46:49] I'm just going to see if the parent's pass my checklist, tick, yeah, alright, tick [laughs]. Erm [pause] so you're *watching*, we might think of it as *informal* or low key, but it's *astute* and *informed*. I can't not. I can't not. I can't not use [cross talk unable to hear 0:47:09]. It's impossible to say it's just about relationship more than when...I can't spend time with anybody who's got children without, at some point, you know [laughs], as you well know. It *isn't* a checklist, it's just, you *notice*, you notice. [pause] You know, I guess it's like a, Mary Berry couldn't just eat a cake, could she? [both laugh]. Yeah, and Sting can't just listen to a record [both laugh] Yes, I'm aligning myself to the, kind of the greats, but it's *so much part of your job*, you know, I dare say, you know, a mechanic would get in *my car*, they're not just going to relax and enjoy the ride, are they [laughs] No instinctively, they'll be like, "Ooh", but they haven't got in thinking, "Oh, I'll assess *this, her driving* and *how* that car engines working", they've got in because they need a lift, but I'm guessing, yeah.

Volunteer 5, Interview 1, beginning at line 439

Line 439: There are definitely pieces of work that are better suited to *other* people, but I'm confident to be able to say, "Don't give me that one" [laughs], "Give that to somebody else, because that is not what I do well, this is what I do well, and *I know* I do this bit really well". So that's a different level of confidence. Can I ask about the bits you don't feel are your bag or that *don't fit* as comfortably with you? **Yeah.** What might they look like? **How long have you got** [laughs]? And is it actual pieces of work or is it a way of working that [pause] *jars* with you? Erm [long pause] Its pieces of work. I think, [pause] I think that, and this is interesting, I can't quite remember the detail of how we discussed my relationship with research and *theory* and reading and all of that, I don't know if, I can't remember to what extent we discussed that, but [pause] I honestly believe that *most* of my work comes *intuitively*. It comes with a knowledge and understanding of reflection of emotion, Hmm and that doesn't come from reading. Reading *supports* it, but as you well know, I don't do loads of reading [laughs] Yeah it's not *that* that fuels it, it's a *very, very sound* intuition and emotional connection that understands and reads what is going on for others Right when they're describing their experience as a parent. [long pause] And it's having the *confidence* to attend to my intuition without the *absolute* need for written evidence to support it, Hmm although it's very helpful to have that written evidence and sometimes *I like* to use that. [pause] But I like to use it when [laughs] I'm kind of, I guess, pulling a punch because I feel that somebody's challenging my expertise, Yeah perhaps. So, again, that comes back to intuition, I *feel* that this person *thinks* they know more because they've read more, so I'll just pull a *paper* out of whatever, so it's helpful, but the ultimate remains the same, it's *an emotional link* that makes the difference.

Volunteer 5, Interview 1, beginning at line 932

Right and what, I feel I've talked a lot about *processes*, Hmm I don't feel I've talked an

awful lot about ASD attachment, and is that okay, *for you*, has it met your needs in that way? Well, maybe you don't think you've talked much about attachment [laughs] and maybe that's a useful thing to pick up next time, because I think, although *you've not named it*, I think a lot of what you've **Right** said is about attachment **Okay** so I would be interested to ask you a bit more about that next time, if that's alright. **Yeah, that's fine, absolutely. I just want to make sure I've met your needs in terms of...** Well, that would be a helpful thing for me to think about when I get the transcript back, check that I've...**Yeah, got what you need.** Because we've zigzagged, haven't we, and we said we would zigzag **Good** so thank you very much.

Volunteer 5, Interview 2, beginning at line 566

You are. And I want to challenge you, because I think *your* hunch would be that's *intuition*, and I'm *wondering if*, despite your best attempts to resist theory, there *might have been* some *theoretical input* in forming your intuition, that quick judgement call that you're able to make like that, about who was and who wasn't a player, **Yeah** maybe that was informed by some sort of *knowledge* rather than feeling. **Yeah, and maybe that's the case and I haven't unpicked, and it's interesting that, you know, we could perhaps spend some time unpicking that.** I guess, [pause] *one* of the elements within the process is that there isn't time and opportunity to deal with it *all* and it's kind of first things first, really.

Volunteer 5, Interview 2, beginning at line 712,

Line 712: **So, if we had a child who entered nursery with *ultimate* confidence and completely flew around nursery, my questions would be, "Okay, so which bits have we missed?"** What do you mean? **In terms of** [pause] *was there anything that that child was masking, or was being masked, in order to cope with what potentially was a very challenging situation for them? I've not explained that very well. So...* Are you making the link with things seeming to be fine then, with, how come they're not fine now? **Yeah.** Does that mean you're using the pre-nursery and into nursery as some sort of litmus for **Yeah** or foundation for the rest? **That's part of it, that's part of it. And I'm *attaching* particular experiences, which are often articulated at that point, with particular ages. So I'm trying to, I don't know if I'm explaining it very well, but [long pause] I'll use a sl [pause] vague example. [pause] So a family of [pause] a few children who *all* experience *considerable* neglect, domestic violence, challenge throughout their early years, and *one of those children*, typically, is presented at teenage as *the one* [pause] *that is different and a problem*, because everybody else in the family has managed it. So *everybody* had *that* experience, why is it *this* child that is not coping? Hmm [pause] So, when I'm talking about, *and he* was brilliant when he first went to nursery, *and he* had been toilet trained well, he walked quickly, all of that, the bits that I'm looking for was *how did he then construct a picture of himself* in relation to his position in the world, as *protector*, as *carer*, as being *the one that manages* at that stage, and then falls flat on his face later on? Those are the types of things I'm looking for, [pause] whereas one of the other children may well have had different needs met, possibly *by* some of those siblings, and therefore their interpretation of who they are in the world *and* the skills with which, the skills which they draw on to maintain their *sanctuary* are *different*. [pause] *Often*, at secondary age, *the child* who is not coping Hmm the question is then raised, "Well, it's because this child is autistic" **Right** "It must be because there's something wrong with this child, because *everybody else* has coped", but the bits we've missed are the fact that *that* child has been meeting the needs of *siblings* in a way, and *soaking* the necessary emotions to *keep* everybody else safe, [pause] and that's the reparation that's needed. [long pause] So,**

rather than there being something *wrong with that child* Hmm because they are now bouncing around the room punching holes in furniture, smashing things up, threatening, abusive, whatever, whatever, rather than perceiving [pause] an inadequacy, what I'm focussing on is, "Do you *realise how competent* that child has been in meeting the broader needs of the family *unit*, which has *masked* the significance of the need which with which they've been presented?", and *that's what I'm looking for*. So can I name that something? Hmm. Psychodynamic? Hmm attachment theory? Yeah Yeah Would they sit comfortably? Yeah, **absolutely. Absolutely.** It reminds me of reading Patricia Crittenden's stuff when she gives examples of the [pause] high flying sisters who **Right** coast through school, [pause] you know, the two point four, **Yeah** average American family, whatever, and then hit adulthood and off to college, and then go to bits, and, actually, was was the surviving up to that point **Yeah** in a very ostensibly average okay way, actually masking...? **That's what happens. That is absolutely what happens.** Frequently in my work, because I'm picking them up at teenage, that is *what* I'm seeing. Yeah And when I talked earlier about *picking up a narrative* and *attending to aspects* of development that have yet been unravelled Yeah it's *going back to those* and *reinterpreting* those very *positive* early exp experiences, that people *perceive* [laughs] this child to be okay Hmm yeah can't understand *why*, they've fallen later, it's because...It surprises people. Yeah, and it's because that foundation has not been *solid and secure enough*, and [pause] it is, it remains *incredibly important*, which fits with the whole [pause] *ethos* around what I believe to be the right *curriculum* for children, because *the more*, and this links with the *quick fix* kind of Yeah latching on, the more we go *quickly forward* [fast speech] the more we leave behind. We *must* spend *every moment* building sideways, rather than...Upwards. Upwards. It gets blown over in the wind, doesn't it? Hmm. [pause] So, [long pause] systems theory Hmm narrative approach Hmm [pause] underpinned by some psychodynamic and attachment theory Hmm [long pause] and would you be drawing on systems, systemic family type Hmm the powerful experience with the family? Yeah. Your role. And sibling position makes a difference, the *scripts* that are around within families, the *descriptions* that are given to children, the *names* of characteristics. Hmm. Powerful stuff. [pause] The one who? The one who. And that would be possibly linking to things like transactional analysis and script analysis. Yeah, and I have a background in that. Yeah, I use that a lot in my thinking Yeah I don't use it a lot in my verbalisation, but I do, I have I have [pause] a reasonable knowledge of transactional analysis, and I think of interactions using that perspective.

Volunteer 5 talked of her practice drawing, substantially, on intuition. She did not overtly disagree, however, with the suggestion subsequently made, that a range of psychologies could perhaps be identified as influencing her work. Volunteer 5 directly endorsed one of the suggestions made.

Volunteer 8 was the most experienced EP taking part in this study (by length of service and positioned as having done considerable assessment, support and strategic work in the area of autism). She was the Volunteer who had compiled a document of detailed reflections about overlapping phenomenology that we spent much of her second interview discussing and which I

subsequently wove into the Coventry Grid. She, however: positions herself at a distance from theory (having trained a 'long time' ago, feels 'rusty' compared to her daughter who is studying and the trainees on the 'new doctorate' course) and down plays the value of her body of experience in direct contrast to 'research'.

Yet, within the BPS, DCP Guidelines for clinical psychologists (2010) there is an early and clear statement on their position in relation to the value of clinical experience and a desirable connection between practice and research,

“Like other applied psychologists, the background and training of clinical psychologists is rooted in the science of psychology...the ability to design and undertake professional practice with individuals, groups, organisations and systems...is becoming more and more valuable in the drive towards evidence based practice...It is important to emphasise that research is not thought of as an activity removed from the 'real' clinical workplace...practice feeds and draws on research and theory that in turn influences practice” (p3).

Formulation continues to be positioned as a central component of clinical psychology practice, despite a lack of evidence to support it as a specific intervention and there is an endorsement that evidence for effectiveness of formulation should come from practice based evidence as well as evidence based practice (BPS 2011, p23). Furthermore, within those good practice guidelines on the use of psychological formulation (BPS 2011, p7) there is explicit reference to the place of intuition,

“Clinical psychology also draws on the tradition of reflective practice. Reflective practice is a loose term, but implies that the subject matter of our discipline, human beings and human distress, is not best served by the narrow 'technical-rational' application of research to practice. Rather, it requires a kind of artistry that also involves intuition, flexibility and critical evaluation of one's experience. In other words, formulation is a 'balanced synthesis of the intuitive and rational cognitive systems' (p7).

Clinical experience and intuition are justified or endorsed in two sets of professional guidelines relating to the practice of clinical psychologists. I propose clinical experience and intuition are yet to take an equally persuasive place with either commissioners of children's services or a scientific community which both largely privilege the gold standard experimental design in producing evidence based practice. An example of a significant departure from traditionally accepted

approaches to research, has been seen by the response to DSM 5 of NIMH (National Institute of Mental Health), the world's largest funding body for mental health research, who will now fund studies that are not based on diagnostic categories and "is calling for research to be based on experiences of distress that cut across diagnoses" (Johnstone 2014, p14).

In considering some of the challenges to practice becoming accepted as research, I tentatively suggest that opaquely expressed connections with theory and expressions of 'conjecture', 'hunches' and 'subconscious' practices, perhaps inadvertently serve an injustice to the highly nuanced, contextually informed, process driven, critical and reflective practice spoken about by EPs in this study. Burnham's (2013) small scale interview research with EPs about their practice, also using thematic analysis, could be interpreted as making some alternative suggestions. He writes that in his study, most EPs (n=7),

"are ambivalent about the scientific basis of their work and the contribution of peer reviewed research to practice, and that they regard the utility or social value of their professional practice as more important than its congruence with a recognised evidence base" (p19) and that "participants did not reference a clear epistemological framework when describing their own practice" (p20).

I suggest that my analysis of the talk in the current study contributes to the evidence base pertaining to the overlapping phenomenology. Firstly, EPs' statements of observations or reflections from their clinical experience could elaborate or extend those compiled in the existing version of the Coventry Grid. Secondly, I propose that in providing rich accounts of their problem analysis processes, EPs are describing an activity context that facilitates the comprehensive appraisal of the information they gather during that process and thus enables them to robustly justify their hypotheses.

#### 7.5 Research question 4. How do EPs conceptualise the distinctiveness of their contribution to problem analysis in this particular area?

The combined thematic extracts from individual volunteers relating to this question are provided in Appendix O.

In this study, EP identity, skills or distinctiveness of contribution was not a planned domain for exploration. It was chosen as an area for closer examination through the process of analysing the cross cohort thematic mapping (Appendix K) in the context of personal experience of the interview encounters. This process culminated with the appraisal, namely that substantial talk was on reflections on and frustrations about the practice of other professionals and ways in which EPs were different to 'others'. The feelings that volunteers reported being aroused during the course of the casework examples was explored and reconstructed as signals that underlying core professional principles or personal values were being challenged and facilitated the beginnings of a construction about identity: who they are; how do they work; and what do they value. Examination of those aspects of talk enabled a re-framing; from others to self and to EPs' identity. This reconstruction of talk includes reference to skills, training and approach to practice, and the positioning of EPs within LAs (and outside of diagnostic services run by Child and Adolescent Mental Health Services, CAMHS). The talk of volunteers captured in this study, therefore, constructs the possibility of a distinct contribution by EPs within this specific arena of professional activity. This is particularly topical because:

- there is a review of the training routes of Educational and Clinical Psychology (National College for Teaching and Leadership and NHS, Health Education England (2016);
- good practice guidelines indicate multidisciplinary assessment for autism (NICE 2011) and EPs are included as possible contributors; and
- the current national context is raising concerns about equality of access to psychologists in the children's workforce.

A number of factors combine to raise concerns about accessibility of psychologists. The response to my Freedom of Information request to the Health and Care Professions Council (7<sup>th</sup> October 2016) indicated that there were less than 3,400 EPs registered to practice in England. The change in EP training to a 3 year doctorate programme meant there was a 2 year gap with no new EPs joining the workforce. This year, 132 EPs are being trained in England, next year there will be 150. Across the 152 local authorities in England, it is easy to see why there is a perceived lack of EPs. There is an ongoing shift in the demographics of the profession; a period of anticipated loss (with 'baby boomers' retiring) and a substantial proportion of the profession being 'younger' females. National austerity measures leading to cuts in local authority funding from 2010 onwards, has meant that some LAs have reduced EP staffing levels. Some EPs have begun private practice as a direct result of redundancy, others due to the resultant landscape of local authority employment i.e. a focus on statutory work. In addition, the 'Academisation of schools' agenda of central government has direct implications for access to educational psychologists; Academies, placed independently of LA control, are only in receipt of statutory EP services. The changed and changing employment contexts of EPs, therefore, raise important questions about the accessibility of EPs to support the identification of children's needs in a timely and accurate way.

By presenting analysis of EPs' talk about skills, training and approach to practice, and their positioning within LAs (and outside of diagnostic services now exclusively undertaken with Health Services locally), this section endeavours to illustrate the construction of volunteers in this study that the discipline of Educational Psychology is currently distinct from other professional groups.

## Skills, training and approach to practice

Writing about the distinct contribution of EPs, Monsen et al (1998) wrote,

“What discriminates the work of EPs from that of other support professionals? The answer seems to be that EPs not only draw upon a knowledge base in psychological theory and research, but also employ a systematic approach to problem solving which enables them to understand and manage human problems from a holistic perspective” ...Frederickson put forward the view that the unique contribution of the EP lies in the very broad range of hypotheses which they are able to generate in helping those concerned about a child develop a useful understanding of the situation”... (p235-236)

The approach to problem analysis was the focus of the previous section, so this section instead, focuses more directly on EP talk where explicit reference is made to their identities, “as EPs”. I interpreted, this was also often made most clear when comparing or contrasting EPs with other professionals. Extracts are provided next to illustrate the talk of identities expressed in these ways.

Volunteer 1, Interview 1, beginning at line 121

**Schools claim expert status, based on limited training, and make bold conclusions based on very little analysis whereas EPs observe, unpick, cross reference / triangulate to offer alternative hypotheses, interventions and ways of working”**

Volunteer 1, Interview 1, line 213

**“EPs thinking psychologically about a whole child, that perhaps others don’t focus on”**

Volunteer 1, Interview 2, beginning at line 823,

Erm [pause] I wondered if we could say, we talk about the knowledge and skills base *you* would be drawing upon versus teachers, **Uh huh** Erm and you said about teachers going on training and commenting beyond their skill set. So thinking they know it all after having been on a course. **Yeah.** Erm and you mentioned getting reactions from *staff* when you’ve tried to suggest alternatives, “Hang on a minute, let’s think about...” **Hmm** and I just wondered if we could say a bit more about the ways in which you understand the skills skill sets of teachers and EPs differently? [pause] Because it felt like you were *frustrated* with the *training* that they had and what they *then did with it compared* to what an EP does, and I wondered if there was some more to be said [pause] about the skill set of *teachers* and what they do with it. **Hmm, mmm.** [pause] **I think [pause] the subtle difference [pause] for me, between being a teacher and an EP is as EPs we were taught to think of alternative hypotheses [pause] and to look for the evidence for or against.** [pause] **I always remember one key lecture at uni where [name of tutor] said, “Somebody walks through the supermarket door, you hold the door open for them, they don’t say thank you. Why**



didn't they say thank you?" and it was, okay, why else? Something else? *Why* else? *Why* else? And, *for me*, that has *driven a lot* of my own EP practice, whereas a *teacher*, I remember going on a course on ADHD, and suddenly all my kids in my class were ADHD. Oh, right. Do you know what I mean? Er you get that *small* amount of knowledge, and you *conceptualise* that very, very quickly, and you *suddenly* become an expert in it because you've had a little bit of training on it. Whereas, as *EPs*, again, we come back to that ecological model, what *else* is going on? Is it about the knowledge plus the thought process and analytical skills, then? **Yeah, probably.** Because, is what you're saying about the teacher is that they *get the knowledge...They get the knowledge.* ...but not how to use it? **Not how to, yeah, yeah.** And I think, again, having been a teacher and an EP, it's that *subtle shift* in that *application* [elongation] What does it actually *mean*? What am I going to *do* that is different? Whereas, the teacher, you get your training on ASD, suddenly all the kids are ASD. Hmm But we come from it from a different angle. Also think about *what* are we going to do to make things different.

Volunteer 1, Interview 2, beginning at line 767

Well, it's also about, if, [pause] it's about *my* [pause] *my professionalism* in *providing as much* information as I *possibly can* to assist in the multidisciplinary assessment of a child with ASD. And that, I think, has come from, that's *just what I am*, but also because we've been pulled out of the *CAMHS process* in that multi-agency assessment. So, I want to give them *as much in-depth information about how that child presents, in the classroom, in the school, in the playground, to help* in that diagnostic process, because I feel that we've *lost* that now. [pause] And I worry that we go back to the days of [name of Consultant Psychiatrist], where, Oh right. Do you remember? Yeah. Where labels, diagnoses, *whatever*, are just given out willy nilly without that *whole*, [pause] that *extra quadrant* in the triangle that is educational based. But of course they would say they do education. I don't think they do. I don't think they've got the knowledge, the skills, the understanding. [pause] It's a bit like me saying I'll go and work in CAMHS and I'll do some er diagnostic work. I'm not a CAMHS clinician? How can I assess someone with mental health difficulties? I can't. Whilst watching on a ward that you've never visited. *Exactly*, there we go. Yeah. Hmm So, rather than do a three hour school visit, I'd like to see that child in different settings at different times of the day, different times of, [pause]. Do you know what I mean? It's about...

Volunteer 1, Interview 3, beginning at line 32

I think, as a practicing *EP*, you've got in your head certain things that are, I don't want to use the word *red flag*, but are things that you [pause] find your ears *prick up at* a little bit *more* than they would do for maybe something else Right or for *somebody* else.

Volunteer 1, Interview 3, beginning at line 445

I've got here about too many going through diagnostic processes, and I wondered if you were comparing now with *now*, whatever *now* is with *before*, whenever *before* was, so I've put since when and is there again diagnoses coming through left, right and centre? Erm Is there again here a sense that some sort of core value principal is being *eroded* or expected professional practice that's being affronted? Like an artist looking at something ugly [both laugh] is kind of what I, some sort of *grotesqueness* going on [pause] that, you know, almost

a mess that you couldn't bear to look at. I find it really sad, in a system [pause] that worked well, that involved [pause] the EPS providing educational perspective is being eroded. Because you went on to say that people with *no background in schools whatsoever*. Yeah. And *today*, whilst I was at *panel*, we saw some paperwork that has come from CAMHS where next to, it's like a table, and they've got clinician information and what it is they wanted, and parent, speech and language, cognitive, next EP, no EP information received. And I just thought, "Is that *all* they *value*, the EPS for, doing a cognitive assessment for a child with possible ASD?" whereas *before* we were looking at how does the child *respond* in a classroom, *how* can we *mediate* their learning. So you can't de-contextualise assessment? *Oh, God, yeah*. [pause] And, you know, a *nurse practitioner*, *don't get me wrong*, *nowt* wrong with a nurse practitioner, but she is *as skilled* in classroom observation as *I am* in taking out sutures.

Volunteer 3, Interview 2, beginning at line 769

Is there anything else, [name] that you would think is important that we capture? **Anything else?** [long pause] Yeah, maybe one thing about talking to EPs, and that is, we *have* to listen to others and, obviously, respect what they say, that's important and I feel very strongly about collaborative work and partnership working, but at the *end of the day as well* [pause] we we sometimes have to put ourselves on the line and we have a professional responsibility to say what we think, and that's actually a lot of what we get paid for. Hmm And therefore [pause] not to shy away from that, [pause] because it would be very easy just to describe what's going on, [pause] lots of people describe what's going on and they come up with a few strategies, but it's that *middle bit* of saying, "So what you see, what's going on", and you need, and I think that's where I've got to, I'm saying about that *confidence bit*, *it is around*, you know, the world isn't going to go under your feet [laughs] if you say something and someone disagrees with you, but on the whole, most of the time, probably not, people won't disagree with you anyway. Er you *do* have to take that professional responsibility, and I think that's important, because for me that's, because there are times when I think, "Well, that person could have come up with that, but I'm getting paid twice as much as them". The reason being is that, actually, we can say *why* we've suggested that, Hmm base it in theory, but also we'll be the one in the meeting who said, "We think that...". I don't know whether you've come across that 'Oh well I wouldn't like to say', you know, and everyone looks to you as the EP because they want *you* to say it, and that's one of the responsibilities that we have, I think, Yeah [pause] which, so you've got to put yourself out there sometimes [laughs] to say what you believe, and as long as you've done all your reflecting, and thinking, your referring back, you know, and you can justify...And so we've kind of come full circle *back* to the identity of an EP, Yeah

My interpretation of the talk of Volunteer 1 is that she constructs EPs are distinct from school staff because of the richness of the problem analysis activity and process with which they engage, and the training they draw on in how to construct alternative hypotheses by looking for evidence. My interpretation is that Volunteer 1 also explicitly refers to the psychological theoretical foundation and knowledge that EPs have due to their undergraduate and postgraduate training and these

features discern EPs from other professionals such as school staff and “CAMHS clinicians”. Volunteer 3’s talk pertains to a constructed discernment around the skills in conducting problem analysis and hypothesis generation, although she does not directly compare EPs with named ‘others’ who might comprise the group, ‘non-EPs’.

Volunteer 8 also spoke about her construction of EPs in direct comparison with other professional groups.

Volunteer 8, Interview 1, beginning at line 221

you know one of my major [pause] *worries* is that *diagnostic* teams [pause] *do, can* tend to be a little bit ticky boxy and they don’t *appear to* have the *background* experience of *actual children*, and *actual families* erm [pause] and really consider, I just see these as *really, really* important questions to *consider* and, at the moment, erm it *is only* kind of maybe gut feeling that *guides* people and that *only* comes from experience. Yeah. So, you know, if people can reach a diagnosis of autism by *questionnaire*, [pause] even if there was some cautionary [laughs] Yeah questions to say please see alternative or supplementaries [laughs] in the event of this, that and the other, that might be, my worry would be, always is, isn’t it, that children end up with a diagnosis where people *haven’t fully considered actually what’s going on*.

And picked up again, beginning at line 242

So, you’ve broadly said NHS. NHS, mmm, mmm [laughs] Is there anything, do you want to say more on that? Well, I think psychiatrists, *if they’re involved clearly* Hmm CAMHS would be the *obvious* service, but I do think [pause] even, well, *any of the people in diagnostic teams*. Speech and language therapists *strike me* quite often as being the people, *as a team*, who’ve probably got the *most relevant* experience because *they also*, in their kind of case work and their generic work, of which they’ll have had *oodles before* they become a specialist, Hmm one would hope for several years. They’ve *seen lots of ordinary* kids [laughs] lots of kids with *other social* difficulties and speech difficulties and other things, so I think, *again*, they’ve got a *strong* sense quite often of erm what’s typical, typical for age, they can differentiate *delayed* from *impaired* and have *some* idea of the *social implications* and they, *generally* speaking, are in a *fairly good* position if the children are young to relate it to the parents, met the parents may be at home. Done quite a lot of stuff which I don’t think, necessarily, CAMHS team, they could do, but *don’t tend, by the nature* of their referrals, they have *far less opportunity* than both of us to see *much more* typical kids. We see kids because we see kids in context, so, there’s generally twenty eight others [pause] because we work in schools. Speech and language, again, see little ones of whom I would guess at least fifty percent, you know, they just see Yeah and they’ve kind of *normalise* because they see them tiny, don’t they? CAMHS don’t have that experience because I think they *tend* to get referrals. *They need to differentiate*, speech marks, “but naughty”, maybe in parents who are struggling versus mental health. So that they’re, I think we all have in common, one of our core issues is ‘Is this what we’d be expecting?’ So is it naughty children of struggling parents No with [laughs] or did you have them as separately? [Laughs] Well, any combination Right but I suspect they’re kind of going, “Is it

just naughty?" you know, is it parenting where that's where attachment might come in Hmm so you feel they ought to be the service that should, maybe could and should pick up on it. *However* [elongated staccato syllables] they seem to be, at the moment from the way they work, the *least well placed to have* [pause] *good bonds* with parents, simply because most of the time it seems to be we have to go to them, they have to *come to CAMHS*. It's that doctor patienty thing, isn't it? Mmm. And of course they've just admitted at strategy that they don't know anything about child development. Yes [both laughs]. I've never heard anybody say that *directly*, but that would be my *feeling*, is that for most of the time, *even* psychiatrists, I would think have *scant*, you know, they might have their own children, if you're lucky Yeah but generally speaking, probably have *very scant* experience of of typical kids *or even* what schooling's about nowadays Yeah and, you know, what's *related with that* as an example, er *doctor training register*, we've just been asked, I've just been asked to, if *I would* er *facilitate* the qualifying doctors with their training, which would be *a couple of hours* to make it more meaningful, *a couple of hours* [slow speech] in a *mainstream nursery*. If that's all they get to know what *normal is*, given psychiatrists will then build on that, and they, you know, because even paediatricians, they're going to, generally speaking, they will see some, where they do it from the child development point of view Yeah but *doctors* will see poorly kids, who are not typical or sociable or any of those things [laughs Yes they're going to be at their most clingy and parents are going to be highly anxious, so unless you've done your, you've *lots and lots of paediatric stuff*, [pause] they don't like Yeah, We are, we're probably uniquely placed to see typical, brackets normal development. Health visitors would have more of that kind of background, but they're not involved.

I interpret that Volunteer 8 construes a similarity between EPs and Speech and Language Therapists comprising exposure to typically and atypically developing children, gathering information in context and over time and developing a relationship with families. I interpret the reference to the clinic based context of work by CAMHS staff as constituting a barrier to collaborative working relationships with families. I also interpret this volunteer to be construing a lack of exposure to typically developing children (as 'yard sticks' of how variations in childhood development may present) and limited knowledge of contemporary educational contexts by both paediatricians and psychiatrists. This volunteer also speaks to theoretical grounding which enables EPs to appraise information (social communication and interaction skills, overall development, abilities and disabilities) in context (of age, in the light of opportunities) rather than just gather it.

Despite this detailed talk from a number of volunteers pertaining to espoused distinctness of EP contribution, Volunteer 8 also wonders whether it can be problematic for EPs to be well placed to

undertake the challenge of this work. She referred to myths about the title psychologist ('as mind-readers who fix things'), having been teachers ('school not being everyone's favourite memory'), not having capacity to develop relationships with families (depending on employment context), and perhaps being 'less accessible' with advancing age (more mature EPs may be, potentially, less attractive to young families in terms of developing a supportive peer collaborations). This talk related to EP identity in broad terms, rather than to skill set per se.

Volunteer 8, Interview 1, beginning at line 1125

**No. No. And, as I say, I don't think psychologists, I wouldn't change the name, but I think you've got to bear in mind that A most people probably couldn't naturally spell it, and if you can't *spell it*, would you trust it? Er teachers, they can, but again, *teacher*, I was a teacher, I think that's, oh, that's pretty ordinary for many people, they say, "*Dear God*, you were a *teacher*", and maybe *that* wasn't their *fonddest* memory, and Yeah immediately said, "Oh, you were a teacher, you were a bossy brr brr brr", and maybe I've *stirred up* a whole load of *other* Yeah things, you know, in my attempt to sort of *normalise psychology* and put it with the education bit. Who knows, who knows? [pause] But I think it is *that fear* that, I will be able to just sit there and look into their minds [both laugh]. I don't know, I still don't think any of us can quite get away with that, that's what psychologists do, isn't it, somehow? Hmm, maybe. And maybe we're *disappointing* because we *don't do that* and kind of we don't [laughs] come up with the, "Ooh, just do that", and the answer, we don't come up with the answers they want.**

My insider knowledge as an EP practising locally positions me such that I also offer an interpretation of the passing references to 'diagnosis by questionnaire' referred to in Volunteer 8's first extract. My interpretation is, that there is a perceived separation of information gathering from psychological interpretation within the practice of the local algorithmic pathway; the CAMHS clinician collecting information from school settings may have little training and expertise about children / families and typical development, and information from schools is collected often in a decontextualized way (standardised postal questionnaire completed in the absence of a dialogue) which is then interpreted by a third party, a further level of de-contextualisation, at the diagnostic decision making meeting.

It was noted in an earlier section that the account constructed by Volunteer 5 positioned her, at first hearing, as if she were a very different practitioner compared with other volunteers. Yet extracted from her talk are aspects, which are interpreted here as directly aligning her with other volunteers' talk around their identity and skills set "as an EP": being able to conduct a procedure (consultation, in her work) with expertise; and solid psychological work, drawing on a range of psychologies (attachment, narrative, resilience, consultation, family / systems, script and transactional analysis, and psychodynamic theories).

The practice of EPs gathering information within educational contexts and the psychological appraisal of information drawing on a diverse range of theories is in contrast with the current application of psychology that has been implemented since EPs were withdrawn from diagnostic processes locally. Those diagnostic pathways can still be considered NICE compliant, as clinical psychology make a contribution instead. In NICE Guidelines (2011), 'EPs and/ or clinical psychologists' are named as professionals who should be part of a multi-agency diagnostic assessment. From this wording, it is not clear whether NICE considers their respective contributions as directly comparable and, therefore, also, somewhat immaterial, which discipline makes the assessment contribution. It is pertinent to raise the question of comparability of contribution.

LA EPs no longer contribute to diagnostic assessments for autism in 3 out of 4 localities in the region where this study was conducted (the 4<sup>th</sup> operating on EPs' 'good will') due to more recent commissioning arrangements. Instead, adjustments to the make-up of diagnostic teams have meant clinical psychologists make a contribution. Experience locally is that those contributions are qualitatively different to that of EPs, not a difference that NICE authors would be necessarily cognisant of. Clinical psychology contribution has tended to be in the form of supervising assistant psychologists to undertake WISC IV assessments in clinic (part of the local algorithm) and attending the diagnostic discussion at the end of the information gathering process. In other words, the

psychologists now attending the diagnostic discussions may not have been directly involved in the formative stages of the assessment process; through meeting the child or young person, or having observed them in one of their familiar environments. This does not resonate with the practice of psychological formulation described by Johnstone (2014) in literature review chapter 4 and appears a very different psychological contribution to the work spoken of by volunteers in this study: the psychological contribution of an EP who has done ‘front facing’ ecologically valid assessment and engaged in a problem analysis process over time. The BPS (2010) writing about the discipline of clinical psychology, states

“Critically, it is the mixture and synthesis of [these] competencies, built on the body of psychological theory and data, which are applied to helping individuals, groups and systems solve personal, family, group, strategic or organisational problems that makes clinical psychology unique in *health and social care*” (p8) [italics added]

The BPS (2010) continues that clinical psychologists are,

“in the best position to advise on the psychological needs of the communities they serve and how such needs might be fulfilled. Because of their historic position in the NHS and their numbers (they are currently the largest group of applied psychologists) local lead clinical psychologists can advise on the skill mix required to fulfil psychological needs. This will include ensuring that different types of applied psychological skills are properly represented in the portfolio of services offered and there is an appropriate workforce employed to do the job... (p14)

Explorations into the potential modification of EP and clinical psychology training routes (National College for Teaching and Leadership and NHS, Health Education England 2016) will perhaps judiciously appraise distinctions between the disciplines to ensure that essences of value to both, situated in their current hosts (Education, Health and Social Care), could be harnessed by future training programmes.

### Positioning of EPs within LAs

The location of professionals working contexts may shape the possibilities for their practice. Two examples are provided about the impact of traded services contexts (schools as direct purchasers of EP time).

Volunteer 2, Interview 2, beginning at line 227

"[unable to hear 13:11] a focussed observation *in the meantime*", so I wondered if you were considering there that there was an opening for assessment *over time* **Yeah** rather than it being completed in one sitting **Yes in an ideal world. Yes, and I think, you know, thinking about things like the Coventry Grid, you really need assessment over time because you'd have a hypothesis, erm and I think it even says things like, you know, if, er you know, [pause] if it's an attachment issue and, you know, the situation's changed, then you would expect the child to improve, where you wouldn't necessarily expect that, so, I mean, that kind of implies that you're being around over a period of time. Yeah. [long pause] Erm [pause] But you've already mentioned although that, I suppose, time is one of the things, you're not always at liberty to *choose and direct that*, are you? **No, no, very rarely. Well, these days. Yeah Far less than you could before.****

Volunteer 1, Interview 2, beginning at line 714

**It's also, erm it then becomes *my problem*, or it becomes the specialist *learning teacher's problem*, it's not *our problem*.** Right. [long pause] That doesn't really fit with consultation, does it, in terms of problem ownership and...**No, it doesn't.** Are they also then the schools that don't ask for a consultation, they ask for an assessment? **Well, we've moved away from consultation as a model really, which is a bit of a shame, erm because they're *buying* us in, that's the trading model, isn't it, that's what they're asking for, that's what they *get* because that's what they're *paying for*. It's *easy* when you're working in a school that are buying in twenty sessions, you can still do a consultation and they appreciate it, but if a school *just* wants the quickest, you know, quick one off assessment, you've got to try and do it all in that *one* session. But I think [pause] if I'm working *in the school that consistently passes the buck, or consistently doesn't look at what they are doing, and labels the kids, I've got to [pause] work with that school to help them understand*, [slow speech] [pause] understand *why* the things that are being seen are being seen, to *educate* them as well. It's moving that on from that individual work, isn't it, to systems work. [pause] So, for example, another primary school in which I've worked, *lots* of assessment work around young people who've got low cognitive scores, [pause] you know, like kids in year 5 who were still at P8s Hmm and level ones, and they want, they started off wanting the same type of assessment. **What we can do *now* is, *with that relationship*, is actually *talk to them* about what we're going to do for *all of these* kids. So you don't have to have that individual assessment. Hmm You can do exactly the same, I think, with ASD and attachment.** Hmm I wonder if, my question here was about the pressures on you and, you know, Uh huh**



Volunteer 3, indicates that her designation as a Local Authority representative provides a mandate to 'find out what is going on' and refers to her sense of responsibility for that, rather than embedding it within a talk of restrictions on her practice.

Volunteer 3, Interview 2, beginning at line 802

**Yeah** And what it is we do and how we do it and why it's different to other people who turn to us in meetings and say, you know, "Over to you". **Yeah. And I guess a lot of that is part of their role, being employed by the local authority as their representative to find out what's going on, which is quite daunting.** It is, isn't it? **It's going to be, for younger, newly qualified EPs, I think.** It daunted me in the beginning. **Yeah, it did with statutory advice, it's like [squeals], "This has got to be right".**

Volunteer 1 also speaks to the value of being located within EP services, where access to colleagues and experienced practitioners provides a rich a resource that can be drawn on in casework.

Volunteer 1, Interview 3, beginning at line 527

[long pause] And I think a lot of my understanding around ASD has come through things like peer supervision [pause] and reading other people's reports as well. [pause] I've got this ability to connect useless pieces of information, oh, no pen, sorry, I'll stop. No, go on. To connect what might seem *stupid* pieces of information and then go back and *check* and then, or *put that* into my little understanding formulation for *something*. I can't think of an example. Erm But it's about noticing...It is, isn't it?...making links. It is and it's about *not being scared to actually go and say to somebody, "What do you think that actually means?"* Do you mean ask the people in the schools or your colleagues? **Colleagues.** [pause] **Yeah, I mean, after fourteen years, I *still don't* feel, uncomfortable asking another colleague for advice, and I think that's about being that reflective practitioner, isn't it, there is *always something new*.** I think, [pause] as much as [name] was our specialist EP, she didn't necessarily give us any *specialist* advice, but when she started to use the stuff from the autism research centre, she didn't *say, "Try using that"*, it was very much a case of, *"I saw you using it on the internet, so I went and Googled it"* and that's how I increased my knowledge. Right. Down that way. So some of it's *accidental* Hmm that I've got over the years, and some of it has been [pause] through direct discussions and peer supervisions. [pause] But it's a *constantly evolving theory*, isn't it, psychology **Yeah There was always something new, and I think, *as practitioners*, if we've got something new, we should share it. With each other? **With each other, absolutely.** [pause]**

EPs have spoken about the exercise of professional autonomy in their practice, being able to make decisions about casework approaches depending on individual circumstances, and 'the freedom' to change course when they judged this was appropriate. EPs spoke of exercising autonomy even

when working in contexts where pressures for certain activity were present. For example, an extract was provided by Volunteer 7 when discussing research question 3b, and the contextual factors influencing problem analysis. The exercise of professional decision making in determining appropriate assessment activities in individual circumstances I argue is embedded within the talk across volunteers about their problem analysis processes.

This is unlike the psychological contribution that is assigned to clinical psychologists as sited within the local diagnostic pathway. The pathway follows an algorithm written by a psychiatrist, where the same standardised cognitive assessment (WISC IV) is prescribed for all children going through the pathway. Two aspects of this practice are noted here. Firstly, the uniformity of approach to psychological assessment is in direct contrast with the professional discernment of EPs unique to each situation as discussed in this study. Secondly, within the local algorithm, the profession of psychiatry, as authors of the pathway, are directing the contribution of clinical psychologists (who conduct the assessments), which also stands in contrast to the responsibility retained by EPs for practice decisions. EPs, through their LA employment context, could be argued to have greater autonomy and flexibility of practice than their clinical counterparts working in the context of the diagnostic pathway.

Volunteer 8 spoke of 'others' approaches to diagnosis by questionnaire, and reflected on her major worry about diagnostic teams which are 'ticky boxy', and assessment conducted by individuals with limited experience of children and families to be able to fully explore / consider 'what is going on'. She is concerned whether new processes without EPs capture 'the development of stories over time in arriving at a current situation' and whether histories captured by questionnaires, also explore family functioning in addition to the child or young person's presentation. A number of researchers' works addressing the use of tools in diagnostic processes were noted in Literature Review Chapter 4. Cosgrove and Regier's (2009) concerns were about an overreliance on 'tools' in diagnostic processes

and Cohen et al (2010) suggested that triangulation of evidence from multiple sources including direct observation were crucial and could not be replaced by a tool. EPs within this study talked of conducting assessment activity determined appropriate in a given context (i.e. with ecological validity) embedded within a problem analysis framework. I raise the question whether flexibility and criticality within EPs' practice, perversely, helps explain why [some] "many potential users of, or stakeholders in, the profession of educational psychology may have relatively less well developed understandings of the EP role" (Fallon et al 2010) [for example, when they do not seem to do what other professionals expect them to do as in the casework example drawn on by Volunteer 7]. Is this approach confusing by its variability whilst the predictability and uniformity of algorithmic processes, which adopt 'designated tests and tools' that measure 'real' things more befitting essentialist positions which predominate, and perpetuate, the deficit discourse of neoliberalism (Sugarman 2015) and the paradigm of psychiatric diagnosis. When EPs 'sit with mess and complexity, wonder and want to be curious' (Volunteer 7) this perhaps reflects a step towards constructionist perspectives that are not [yet] mainstream, despite the 'reconstruction' of the profession in the late 1970s (Gillham 1978)

Bartolo's work (1999) referred to in Chapter 4 highlighted assessment biases within professional activity. It is a possibility that assessment processes located and conducted entirely within Health may be more subject to those biases.

## 7.6 Concluding remarks

Problem analysis in this area of overlapping phenomenology poses particular challenges as assessment and conclusions are based entirely on clinical interpretation of observable behaviours. EPs, with their specific training and by their working contexts, are suggested by this study to be well equipped and well placed to work on this problem analysis. The constructed distinct contribution of EPs is that all of the following dimensions are contained within one discipline. EPs:

- 'do' schools - EPs working within a locality are well situated due to their relationships with, and knowledge of local schools, and their knowledge of schools as institutions and of educational and pedagogical practices. They are therefore able to interpret and make sense of behaviours within the contexts in which they are observed. Working within local services means they have a rich clinical experience of their peer group to draw on in their work;
- have a knowledge and understanding of typical and atypical childhood development;
- are able to work across the age range (0-25 years age range);
- have skills and knowledge in working with children and young people of different abilities, (those considered to have learning difficulties and those without);
- conduct contextualised, and therefore ecologically valid assessments by working in contexts in which children and young people are familiar;
- conduct assessments through activities that are judiciously planned based on individual factors thereby providing individually meaningful assessment outcomes;
- engage critically and with awareness in a detailed and complex problem analysis process over time to generate hypotheses; and
- are able to apply psychological theories to the interpretation of data.

Given this endowment constructed from analysis of research discussion, it is perhaps intriguing why EPs have ruminated for over a decade about their 'identity, role and niche' (Thomson 1996, Leyden 1999, Gersch 2004, Cameron 2006, Ashton and Roberts 2006, Gersch 2009, Love 2009, Gaskell and

Leadbetter 2009, Boyle and Lauchlan 2009, and Fallon et al 2010). It is noteworthy, that a number of these dimensions been given light through the re-framing of talk about constructions of what it is that others can and cannot do, rather than being directly articulated or owned, 'first-hand'. Earlier in this chapter, expressions of 'subconscious' or 'automatic' ways of working were detailed as open to reconstruction through engagement with this research process. The supervisory function afforded by engaging in this research was set aside as a background dimension at the start of the findings chapter. An ongoing focus on the distinctiveness of educational psychology practice in the supervision of qualified EPs, might be supportive of a clear ownership and articulation.

It is important that the profession can clearly articulate the distinct contribution and endowment of its discipline.

"... without evaluation, EPs do not know what aspects of the work are actually worth doing and, in a consumer- led, value for money culture of the 1990s, how long can we afford to be in that position?" (Monsen et al 1998, p247).

This is now perhaps more pressing in the current climate of reduced local government funding, traded services, joint commissioning and so forth where the time resources for comprehensive psychological problem analysis are under pressure in new ways and 'quick wins' (and especially cheap wins) appear attractive. The costs and benefits of educational psychology are being examined (Gibbs and Papps 2016). On advising commissioners and providers the BPS note that,

"It is important that providers and commissioners of services are both clear about the nature of the psychological needs to be fulfilled in order to ensure that the appropriately qualified psychologists are employed" (BPS 2010 p14).

From the perspective constructed in this study, it is proposed that EPs are currently equipped and positioned to make a distinct contribution to differential assessments exploring the overlapping phenomenology of autism and the enduring effects of attachment experiences.

## **CHAPTER 8**

### **CONCLUSIONS**

The aim for this research was to make explicit and illuminate accounts of EP practice within a specific domain; the perspectives and problem analysis processes of EPs when attempting to differentiate the overlapping phenomenology of autism and the enduring effects of poor early attachment relationships.

I anticipated the research process and accounts constructed to be of value to me, the researcher, as an EP who was yet to articulate my subject perspective in relation to the questions planned. I hoped that volunteers would find the research process of value in stimulating their reflections and bringing to the fore their experiences having had dedicated time and space to talk about their professional perspective in relation to a defined topic in a structured way.

#### 8.1 Strengths and value of the methodology

I propose that this qualitative study can be evaluated positively against the systematic, sceptical and ethical dimensions which comprise the explicit, rigorous and transparent endeavour of research as framed by Robson's (2002) "scientific attitude" (p18).

The constructionist approach to the interview process as a method of enquiry has afforded an opportunity to construct and explore accounts of practice. The method of enquiry and approach to analysis, have proved suitable in answering planned research questions. The flexibility inherent in the interview approach and on behalf of me as researcher during analysis has sparked new insights and enabled planned research questions to be considered within a context of complementary

questions. The recursive interview approach provided opportunities for reflexivity within the research process and therefore the consideration of how my own views and biases might have been interacting with the views and experiences discussed with volunteers (Darlaston- Jones 2007).

My approach to this study might reflect some of the essence of formulation as expressed in the BPS (2011) good practice guidelines on psychological formulation (p7). In working with EPs' to construct accounts, I have checked during the course of discussions whether I am understanding their personal meaning, checked for permission about direction of talk, and contributed to discussion in a way that has helped people make sense of their experiences. In the re-telling of their accounts, I have aspired to offer a 'plausible account' that has further utility, rather than an 'expert pronouncement'. The interview approach was planned with great care centred on the needs of volunteers and the strengths of the 'interview set up' were commented upon by volunteers as conducive to authentic engagement. They also commented upon the attractiveness of the approach as a means of supporting reflection. In this sense, the approach to interview adopted in this study has enabled 'honest' accounts to be constructed. Just as "all formulations are partial and dynamic...they are broad snapshot summaries of complex evolving stories" (p10), this is also what my research has offered; an account of local practice, constructed over a specific time frame within the specific interactional practices.

## 8.2 Limitations of the study

The use of an iterative interview cycle, recording and transcription, and subsequent analysis have been time and labour intensive and highly demanding of data management and organisational skills. There has been much scope for real world problems interfering with this research process. This method might be less attractive, therefore, to a lone researcher, or a practitioner-researcher without dedicated time or work place support for conducting their research. The use of a

professional transcription service did save valuable time but the associated financial costs would perhaps be a prohibitive factor in many contemporary local authority contexts.

The research method developed is an idiosyncratic one that could be understood and 'followed', but not replicated. It is of less utility, therefore, to researchers interested in working within more positivist approaches.

The number of volunteers was small ( $n=6$ ) and all from 2 local authorities in the same geographical region. As such it has been exploratory: generating deep, rich, local accounts rather than theory forming. The sample was also 'self-selecting', so judgements about representation are not possible. Of eight EPs who volunteered to take part, data were included for six. One had become unable to continue beyond the first interview (with reasons known to be unrelated to the research process). Another did not respond to email invitation to engage with the interview process beyond completing the consent process. I did not pursue the volunteer and they did not refer to the invitation subsequently in the course of our ongoing working relationship. The current study did not have a contingency plan for this eventuality, and it would be worthwhile planning how this could be managed in future research.

Conducted and analysed within a social constructionist paradigm, it is acknowledged that the account given in this thesis is one of a number of accounts that could have been constructed. For example, my interpretation that EPs talk reflected a cautious and judicious consideration of the costs and benefits of proceeding to formal diagnostic assessment could, instead, have been interpreted as a representing reluctance or a distancing from such practices.

The method of the study would have been improved by the addition of a more formal phase of enhancing co-construction as suggested by McCormack (2000). For example, asking a brief series of



questions about volunteers' satisfactions with their account, and my interpretation of it. The study would also have been strengthened perhaps by focused consideration and analysis of my contribution to discussions in my role as researcher (Halcomb et al 2006) and by better use of reflective notes for capturing my thoughts and interpretations during the research process.

### 8.3 Contribution to knowledge

In answering Hart's (2006) question, 'Why do we need this study?', this study explored EPs' experiences of practice in a specific domain, a topic that has not been studied previously; the process of problem analysis within which they generate and gather data to assess the validity of alternative hypotheses, of autism or attachment difficulties, in their generic, school-based work. Data in this study comprised approximately 400 pages of transcript of 15 hours of audio recorded interviews conducted with six EPs. The volunteers had a combined EP experience of over ninety years and occupied positions of main grade, senior practitioner and specialist senior (ASD) roles. This research process constructed, represented and synthesised their accounts of practice, which, prior to the current study lay within individual pockets of experience.

Using this data, this study offers a discussion about the range of practice within a small group of practitioners and has generated new insights. Kelly (2008) comments on a lack of coherent discussion of the range of practice undertaken by EPs and the very different perspectives it may represent. She suggests that this kind of 'coherent discussion or articulation is important at a time when there is emphasis on professional accountability, there is a great drive for transparency in psychological process and decision making, and rigorous evaluation of effectiveness' (p17). In exploring EP practice on a particular topic, this study has enabled EPs to construct accounts of their practice, thereby providing a supervisory or CPD opportunity.

EPs accounts of conceptualisations of autism and attachment difficulties showed some agreement with the predominating literature as did their accounts about the value and possible drawbacks of diagnosis. Despite some expressed variations in practice, the talk of all EPs contained some constant and shared constructions:

- of ongoing critical reflection, on practice and taken for granted theory, of the type directly compatible with the competency standards required of the professional registration of educational psychologists;
- of critical discernment around practice decisions, and
- of a problem analysis process consistent with models described in the literature.

Theoretically, this study has contributed to the practice based evidence about the overlapping phenomenology of autism and effects of early attachment relationships through construction with a group of colleagues with a substantial body of post qualification practice and experience. Those ideas have been woven, I propose appropriately, into an existing document which details the overlapping phenomenology as suggested by other professionals; the Coventry Grid, Version 2 (Moran, 2015). The suggested value added by observations and reflections from volunteers in this study is that firstly, existing similarities, differences and explanations are elaborated. Secondly, other suggested additions widen the focus within the existing Coventry Grid (on the child's behaviour), to include consideration of the impact of the child on the parents and on the professional(s) involved. If these suggested additions were accepted, the revised version could then be used as a working document in further practice-based research to elicit feedback about their utility or to solicit other evaluative feedback from relevant professional groups.

Although a recurring theme over the last decade, and not a planned research focus, the inductive analysis processes within this study has constructed an account of EPs' identity, through a re-framing of their views of other professionals. In harnessing the practice based experience of a group of

practitioners, a clear construction of the contribution of the discipline of educational psychology in the challenging practice of differentiating the overlapping phenomenology of autism and attachment difficulties, was enabled. From the perspective constructed in this study, it is proposed that EPs are currently equipped and positioned to make a distinct contribution.

After some consideration of the effects of working contexts on the shape of EP and clinical psychology practice, it is desirable that explorations into the potential modification of EP and clinical psychology training routes (National College for Teaching and Leadership and NHS, Health Education England 2016) judiciously appraise distinctions between the disciplines located with Education, Health and Social Care, to ensure that essences of value to both, can be harnessed by future training programmes.

Beyond the requirement of the Doctorate to produce a thesis, aspects of this research may be suitable for journal publication. Aspects that might be suitable are:

- EP problem analysis processes for an EP audience;
- the processes of problem analysis and overlapping phenomenology for specific audiences involved in this clinical practice of differential diagnosis;
- the distinct contribution of the discipline of Educational Psychology within a specific area of professional practice;
- the dual role of EP as –practitioner- researcher in the work place; and
- the application of the methodology as a model for supervision.

#### 8.4 Future research

EPs in other U.K. localities may be interested to consider these accounts against their own practice experience, or, as there are no claims to generalisability of the findings of this study, conducting similar studies in other localities within the UK may be illuminative.

Other professional groups might be interested in the perspectives provided in this study, for example, those who work directly with children and young people to identify their needs, within Education, Health or Social Care. Professionals who work directly in the clinical arena of ‘differential diagnoses’ may also be interested in the perspectives constructed and captured by this research. There is very little ‘developed’ or established work in this area.

As the volunteer cohort in this study was recruited opportunistically, it would be useful to conduct similar studies with a targeted group of EP colleagues, such as those who hold local authority specialist senior posts in the topics of autism and attachment and therefore who have ‘domain-specific content-guides’ (Monsen and Frederickson, 2008), or who contribute directly to diagnostic assessment processes. It would similarly be interesting to explore the practices of representatives of other professions who contribute to the work of the multi -agency diagnostic processes.

Future research could also explore the claim that discerning between autism and the enduring effects of early attachment relationships is a worthwhile endeavour because it differentially informs the implementation of strategies and interventions.

#### 8.5 Implications for EPs and Local Authorities

This study proposes that there is a distinctive contribution to be made by EPs, when working with children where autism and or the enduring effects of early attachment experiences may be presenting. EPs, local authorities, and commissioners may therefore want to consider the ethical and

financial benefits of engaging EPs to undertake this distinctive psychological contribution to multiagency clinical work.

This study suggests that this distinctiveness was identified partly, through a re-framing of talk about the practice of professionals in other disciplines. EPs' talk in this study was also indirect with regard to practice; 'intuition', 'gut feeling', 'subconscious processing', and 'automatic pilot' were all open to reframing to more explicit connections with underlying theory and psychological problem analysis. The social constructionist positioning of this study does not lend itself to making direct claims about what such indirect expressions represent. For example, are they simply an artefact of this study's design or are they in some way representative of articulation shared by the wider profession? Direct expressions of identity and practice may be more advantageous in dialogue with commissioners.

HCPC registration requires that EPs demonstrate their continuing professional development and that they receive regular clinical supervision to ensure ongoing fitness to practice. Supervision is not something 'requested or resorted to when stuck' or as something that only inexperienced practitioners require. EPs in this study commented upon the supervisory value of engaging in this research. Engagement in this study was described by one volunteer as a rare indulgence. Another was explicit in using it as a means of revisiting a piece of work where her involvement had ended and she had no yet had the opportunity to process it. Others spoke directly during interviews of new insights and perspectives being generated. CPD and clinical supervision are corner stones of professional registration and quality assurance.

The financial changes within local governments have not only led to changes in employment contexts but may also have led to changes in psychological service delivery. For example, in the part-traded services where this study was conducted, the delivery of 'front facing' professional time outlined in service level agreements has necessarily come into focus. Alongside this, at a service

level, definitions of, and mechanisms for the provision of CPD and clinical supervision, have shifted. Practitioner research could consider the nature of the relationship between changing working contexts and the provision of supervision and CPD. It could also examine the role and responsibilities of EPs and employing local authorities in ensuring the continued access to those CPD and supervisory entitlements.

Research is vital for the ongoing development of both the discipline and the theoretical and evidence base upon which EPs ground their practice. Conducting research is highlighted as one of five core functions of EPs in the Currie Report (2002). One might consider the extent to which providing traded psychological services permits or enables EPs to engage in research. Where local authorities fund EPs to undertake statutory functions and other customers such as schools, often prefer to commission individual assessments, the question arises, 'How will EPs continue to or begin to protect time for undertaking research?' Practitioner research could explore the current approaches of those services where conducting research has remained possible.

## 8.6 Selected Researcher Reflections

The following sections offer some of my reflections on the research process.

### 8.6.1 My reflections on being a practitioner-researcher

Research texts do address the issue of practitioner- research (Robson 2002). As my confidence grew during the course of this study, I began to consider in what ways conducting this research resonated specifically with some elements of generic EP practice.

During my MSc (EP training) programme, trainees were asked, 'What kind of EP do you want to be?' I wanted to be a psychologist whose greatest tools were thinking skills, not something kept in a bag (this related to discussions ongoing during the year about approaches to assessment). In other

words, I prioritised the ability to think through a problem or question and to be able to select the 'right tools' with which to approach a given situation. It has been important to me as a practitioner, to be able to justify and provide a rationale for choices made. It was important for me to demonstrate this rigour in decision making throughout the undertaking and reporting on this study.

In this study, the interview method drew on my skills as a communicative partner, working with volunteers, to elicit and aid the development of their accounts. I judged that this had parallels with the skills applied during Consultation with schools and families, for example. Are the skills of an interviewer the same as, or similar to those used by an EP during Consultation? Are EPs well placed to undertake interview research as this draws on the conversational communication skills they apply on a regular basis? Are good interviewing practices therefore, 'special practices' (like those an EP learns to use in Consultation) or are they simple, everyday conversational practices known to others?

I perceived other similarities between the research process and aspects of EP activity. EP problem analysis includes looking for patterns in accumulated data whilst also being alert to exceptions (analysis, triangulation, synthesis) somewhat like a researcher. Data analysis stages, including the written reporting, resonated with the activity of psychological advice writing. For example, in presenting interpretations, an overarching statement may be made and then extracts provided to illustrate the point made. In writing psychological advice, EPs similarly go beyond the descriptive to clearly report the basis upon which their professional opinions and interpretations are made. The iterative process of data collection and analysis (almost simultaneously) used in this study uses methods is very similar to those utilised by EPs in problem solving processes where information collected at one point helps to determine appropriate next steps.

Having the flexibility to adapt when events do not go as planned, whilst maintaining quality of approach, also resonated as a similarity between being a researcher and a practising EP. The ethical considerations required of this study were a further strand of comparability between the demands on me as a researcher, and as a practising EP.

Cicourel (1964, cited Silverman 2011, p182) makes no distinction between the practical skills of methodologists, researchers and interviewers:

- all are concerned with the synchronisation of meaning;
- all use rules of evidence; and
- all have rules for managing one's presence in front of others etc.

Being a practitioner conducting research in the workplace did give rise to a situation that would not have to be navigated in other relational circumstances. One colleague, who subsequently volunteered to take part, asked for peer consultation on a casework example, just like the scenario under study. Interview cycles were about to begin and so this context posed a unique challenge in knowing how to best respond as their colleague, without feeling that I was potentially influencing the process or content of the research.

#### 8.6.2 The place of emotions in the research process

I have reflected upon the various feelings evoked during the research process. Some are summarised here.

- Frustration with the challenges of real world research such as audio failure, postponed appointments and shortcomings of the transcription service.
- Challenges to competence. There were anxieties around my novice status as a researcher, especially at the early stages of the research process. At times, I felt that the intense thinking required during the process was beyond my skills. There was much at stake with regard to completion and a sense of professional competence.
- Overwhelmed. There were periods of feeling as though the volume and complexity of the data were unmanageable.



- Ambivalence. I experienced feeling torn between competing demands; the personal, the professional, and the academic.
- Excitement and enjoyment. I felt engrossed in the academic challenge of crafting a thesis, and felt joy and excitement engaging in interviews and their analysis.

I have reflected whether other researchers have experienced similar feelings as they are often absent from written accounts of research. I do not recall being prepared to appreciate the significance emotion could have during the research process. What views do other researchers have about the place of emotions during the research process?

#### 8.6.3 My subject position as a practitioner-researcher

My professional practice preferences are for the use of structures and frameworks to help guide my processes and therefore help me manage the complexity of real world problems that are often presented. This preference generated some anxiety when I realised that I was designing a research process that gave power, choice and flexibility to volunteers. My manifest concern was how others might perceive the rigour of the study. How would I convince or persuade peers that the study was well conceived and well executed? What in fact was illuminated was my own underlying concern about what it is to be credible. I realised that this discomfort related in part to my professional journey. In the introduction of this thesis, I recalled the comments made by referee in support of my application for a place on the Doctorate programme. She wrote that “at that point in (my) development” my comfort zone was with “truths, what was real and with certainty...black and white thinking, getting ready to move towards uncertainty, a version of the truth, a version of reality, and accepting shades of grey”. I realised too that, ‘moving towards uncertainty and ‘version of truth and reality’ related to my personal journey and identity as an adoptee (Lifton 1994). My sense of being credible as an individual had partnered professional positivistic definitions of credibility for some

time, and diverging from that perspective to embrace alternative, constructionist notions of credibility had perhaps symbolised a shift of enormous personal significance.

I also mentioned in the introduction that my personal journey led me to the discovery that a birth relative had a diagnosis of autism. That diagnosis came later in her adult life and after significant emotional costs to herself and family, and financial costs to the tax payer. Had the underlying causes of her challenging behaviour been identified whilst at school, her life experiences and outcomes may well have been different. Being a 'Person Connected with Autism', or a PCA (Hackling 2014), does mean that my personal experience influences my professional orientation to the topics of this study. I was vigilant that this personal perspective was not shared during interview processes.

My relationships with the volunteers were varied. As already described, two were former colleagues who were approached as possibly willing to take part in pilot stages. The perceived advantage of their assistance was based on the assumption that, as we had maintained a friendly and collegiate contact after our direct working relationships ended, there was a level of rapport that would facilitate honest and direct feedback which could be put to constructive use. I had a less instinctive understanding of the nature of my professional relationships with the other volunteers. Some I had worked with for a number of years within LA 2, but working relationships with some had more recent beginnings. I imagined that volunteering to take part indicated a level of trust on behalf of volunteers in my professional practice and trust in the process I outlined in the briefing and consent stages. Engaging in the interviews with colleagues, I realised that I knew less about their perspectives on practice than I had imagined. This surprised me. My previously held expectations had been of similarity / uniformity, as all those volunteering worked in two services which operated similar models of service delivery.

All volunteers but one engaged in two interviews. Volunteer 1 engaged in three. I re-visited this to identify possible explanations. One explanation is that more interviews were needed because this was my first attempt at interviewing in this study. My confidence in my style of interview (staying with open questions, trusting myself not to import my views, and comfort with the flexibility of the process) developed the more interviews I took part in. In addition, pragmatic factors (scheduling interviews in her own time so that they fitted in against family commitments) combined with inexperience (being unclear how long might be needed) meant that the first interview was perhaps shorter than it might have otherwise been. An additional explanation is that Volunteer 1 spent a considerable proportion of her second interview providing me with feedback on her first interview.

#### 8.6.4 Other reflections on the value of this research

This research has led to some new understandings for the volunteers who took part. Through undertaking this research I have a new appreciation of the process and tenacity that belies the sophisticated succinctness with which published work is presented. I have also developed my research skills and understanding of the research process. The perspectives shared by volunteers have enabled me to more comfortably sit, for the time being, with the complexity that is posed by casework scenarios such as the ones discussed. Their participation has also enabled me to more clearly articulate my own perspective. For their contributions and trust, I am grateful.

The concluding sections of this thesis have already suggested directions for future research. A test of the strength of the current study could be in its communicative capacity (Mellor 2009); can others interested in this area understand what was done, and why, (relevance and method) and can they use this work as a platform to undertake other research strands (suggested or other), to enhance our understanding and practice in this area.

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## APPENDICES

## **Appendix A**

### **Notes for the oral briefing**

#### **Background**

Doctorate study – Started 2005/6. All taught modules completed. Now able to move on to the final section: conducting a piece of original research which will be written up in a 50,000 word thesis and which will be subject to oral examination (i.e. viva)

#### **Area of interest**

##### My orientation

A review of my research diary revealed the following:

- a case work stimulus to my interests – location / origin of ideas in my practical work, and then linking this to theory;
- a focus on exploration to achieve understanding;
- a focus on the particular case / situation and not large scale generalisability
- an acknowledgement of context (specificity);
- a preference for frameworks to structure my understanding;
- a preference for conducting a piece of research that will adopt a collaborative approach to exploring practice; and
- an approach that is non- evaluative.

##### The topic of the research questions

The overarching research questions relate to the topic of EP problem solving processes when challenged in casework to consider the competing hypotheses of attachment and autism as possible interpretive frameworks for understanding or explaining the behaviour (functioning) of a child / young person.

##### Who might like to take part?

Any EP or TEP who has experience of this particular problem analysis scenario.

##### The shape and nature of the research

- Preparation for the interviews - It might be helpful, to you, to think of (a) recent example (s) where you have felt challenged in your casework to consider the competing hypotheses of attachment and autism as interpretive frameworks that might best explain a child / young person's behaviour / functioning. Consider bringing

along a case file to the interview; whilst identifying features cannot be shared, some might find it beneficial to be able to refer directly to case notes.

- When planning time to take part in the research, consider that interviews might last around an hour.
- The research process will take an iterative approach, where ideas stimulated during initial interview will be explored in more detail on subsequent occasions, so that a fuller account that satisfies you is achieved.

- Interview structure

- The initial interview is semi structured using open ended questions to guide our discussion with the aim of enabling you to begin to develop an account of your practice. These pre-prepared questions are intended to offer a structure to guide the interview process and are not intended to determine discussion absolutely.
- The transcription of this initial interview will be made available to you to stimulate reflection prior to a subsequent interview (which will be arranged within 3 weeks of the first). To facilitate the second or subsequent interviews, you will be able to highlight / annotate the transcription with indicators where you would like to expand your account in more detail. The researcher will similarly annotate the transcription where further exploration would be helpful in addressing the research questions and where further clarification is sought on ideas expressed so that a shared understanding is maximised. This bilateral reflective preparation will guide the content and process of the second / subsequent interviews.

- The role of the researcher

- It is the aim of the researcher in this iterative interview process to act as a facilitator, enabling individuals to construct an account. Thus the researcher will take an active part in the interviews; a collaborator in your construction.
- It is accepted that individuals may have varying constructions of the issues under discussion – the approach to research embraces this and does not favour particular conceptualisations.

- The experience of the research process

- Feedback from pilot interviews was that engaging in the process served a useful reflective practitioner function. It was an opportunity to make the tacit, explicit. In doing so, the thought provoking aspect of the process was experienced as challenging at times.



- The timescale for completion
  - Individuals may not require the same number of interview sessions to arrive at an account that feels familiar and satisfactory. The consent form gives more detail on timescales for data collection and analysis, and where the period of 'right to withdraw consent' ends.

#### The consent form

- Agreement for completing the form

## **Appendix B**

### **Doctoral Research Briefing and Consent Form for Participants**

#### What is consent?

Consent is often referred to in the literature as informed, active or voluntary. Consent for this research will be:

- informed (you will be provided information upon which to base your decision whether or not to take part);
- active (signing the form will signal your active agreement to participate); and
- voluntary (your participation is freely given, with no sense of compulsion).

#### When will consent be gained and how long does it last?

Gaining consent of participants is an essential ethical undertaking before starting research related data collection with participants.

By signing this form, you signal that you offer your freely-given consent to participate. At each stage of the research process in which you are directly involved (for example during subsequent interviews), continuing consent will be discussed and re-affirmed. Outside periods of direct engagement, your ongoing consent will be implied unless you state otherwise.

A wish to withdraw consent can be made orally or in writing (letter, note, email etc). It would be useful to the researcher, but not a requirement on your behalf, to have some discussion about your decision to withdraw consent. This is so any troubling issues can be satisfactorily resolved, and / or so that lessons can be learned to help avoid any difficulties that have arisen in future research.

Your consent can be withdrawn from this study at any point up until a draft of the data analysis has been submitted to the University of Birmingham. Due to the iterative nature of the analysis in this research, I am unable to confirm a precise date for this at this point. I will be able to give advance notice once the period of data collection and analysis looks like it is approaching a conclusion.

#### Why do I need to sign a form?

The purpose of having written consent is to safeguard both participants and researcher. It is a researcher's duty to ensure that participants understand:

- i. the purpose or aim of the study in which they are taking part;
- ii. the potential risks or discomforts, and benefits of the study; and
- iii. how participant confidentiality will be maintained as they relate to the study.

This consent form is a written record of the information provided about the study by the researcher to the participant prior to the research beginning. The following section of this

document provides a summary of the study. The final section provides the formal agreement of informed, active and voluntary consent.

## **i) INFORMATION PROVIDED ABOUT THE STUDY**

This study is being conducted by Fiona Alexander, Specialist Senior EP, a local authority employee, as the final part of her Doctorate study at the University of Birmingham. It is a University requirement that the research be written up in the form of a 50,000 word thesis which will be subject to oral examination (i.e. viva).

This study will take a qualitative, iterative and constructionist approach to data collection and analysis. This means that colleagues will be asked to take part in an initial interview, which will be recorded and transcribed. The transcription of the first interview will be provided by a professional transcription service with the researcher making subsequent amendments to the draft based on further listening of the audio recordings. The researcher and colleague will then work collaboratively on further occasions to arrive at a final, if provisional, account of their individual perspective. All interviews will be audio recorded for data analysis purposes. Fieldwork notes may also be taken during the interviews.

The aim of the study is to understand more about EP problem analysis with regard to the particular issues of Autism Spectrum and attachment related behaviours. The study aims to be illuminative in nature. This means the interest lies in understanding how EPs work on this question, and its aim is not on evaluation of practice.

Broader analysis for the requirements of the thesis will include comparing and contrasting participants' accounts, so that areas of commonality / difference can be noted.

Colleagues who have taken part will be provided with a customised research report once the thesis has been submitted. This report will provide a summary of the research, so that the main findings can be shared without recourse to reading the entire thesis. This research or parts of it may be written up for publication in a peer reviewed journal.

## **ii) POTENTIAL BENEFITS AND RISKS**

### Benefits

This piece of research will be original in its contribution to the existing literature in this field. There is already literature about the nature of ASD, what it is, what are the signs of ASD and so on. Similarly information is readily available in the literature regarding the nature of attachment patterns. There is also literature about an overlap of observable features of the two presentations. There is less information in the literature about what it is professionals (EPs are just one example) do or think when trying to consider the question of whether an individual's presentation could be better accounted for by an Autism Spectrum or attachment pattern framework.

Individuals taking part in this research might find that it affords an opportunity to reflect on professional practice in a way that is beneficial. Participation would also make a legitimate contribution to their CPD log in line with HCPC guidance. EPs will be able to use some of their annual 'CPD allowance' to take part, meaning that this benefit would come without the cost of their own time.

## Risks

This research is no different to other research in that:

- Any disclosures by participants of harmful/ illegal activity during the research process will need to be reported (this is considered unlikely as the content of interviews will be professional practice issues, not personal and / or sensitive issues); and
- Issues pertaining to the Protection of Children would always need to be prioritised over agreements of confidentiality (an unlikely yet real example, would be if the interview process highlighted potential Safeguarding issues).

In either of these circumstances the researcher would first approach the relevant EP / participating colleague. Together they would then arrange a three-way supervision session with the Principal EP so that the issue could be appropriately addressed in line with Service, HCPC and Local Safeguarding policies.

The risks to participating colleagues inherent in this research are anticipated to be minimal because they:

- are not one of the vulnerable groups typically defined in the research ethics literature;
- are considered able to give informed, active and voluntary consent;
- will not be required to undergo physically invasive or emotionally challenging procedures; and
- there are no elements of deception or coercion in this study.

It is possible however, that professional reflection stimulated by taking part in this research, and discussion amongst participating colleagues outside the formal research process, could lead to evaluative comparisons being made with potential threats to an EP's occupational standing. A concerned EP would be urged to bring this issue back to the researcher, or alternatively to formal supervision if preferred. This is so that supportive action can be agreed.

In addition, whilst the study aims to be illuminative (not evaluative) and adopts an approach of egalitarian collaboration between the researcher and participants, it is feasible that colleagues could be concerned about a power differential: as their colleague, I am also a researcher exploring an area of special interest with a level of expertise and experience. A concerned EP would be urged to bring this issue back to the researcher in the first instance, so that it can be explored and supportive action be agreed. Should the EP feel that the issue remains unsatisfactorily resolved, formal supervision would be an appropriate next step.

### **iii) CONFIDENTIALITY AND ANONYMITY**

#### Confidentiality

All data will be collected on work premises but all audio recordings / written records will be kept at home in a locked filing cabinet when not in direct use. Electronic records (research data) will be stored, in accordance with the University of Birmingham's protocols, on the University's network with back up copy on a personal encrypted USB. The USB will also be kept in a locked filing cabinet. Data will be gathered and maintained for the purposes of the research.

For the purposes of data collection, analysis and reporting, each participating colleague will be identified by the researcher through use of a code in place of their name. A record of

names and corresponding codes will be kept separately from other paper records, again in a locked filing cabinet. Individual interview recordings/ transcripts will be heard / seen by the transcriber, researcher and the individual concerned only, and will not be shared with the wider group of participants during the research.

Confidentiality during the research will be observed by me as researcher through routine aspects of professional EP conduct, such as not discussing individuals' contributions with other participating colleagues during the research, or outside of the formal written reporting. Confidentiality is assured in these ways, unless respondents opt to comment on their role as research participants to others.

### Anonymity

As this study uses a 'face to face' method to data collection (i.e. interviews), the identity of colleagues and their responses will be known to the researcher. In addition, raw data (interview transcripts) and figurative summaries of transcripts are likely to contain information identifying individuals (which cannot be predicted or circumvented, and in fact may form important parts of the analysis). These figurative summaries and raw data:

- would be provided in the data analysis / discussion chapters or Appendices of the thesis (which will be available via the university E-thesis resource);
- may appear in the research report provided for participants at the end of the study; and
- may be included in any publication of the research.

Non participation of some EPs may immediately highlight the identity of another. For example when describing participants, one of the two trainees might not participate, by default identifying the other who did.

**All these features mean that guaranteeing anonymity is not feasible.**

Having read this document, do you have any questions that have not been answered?

If you are happy to take part, please proceed to the next section of the form and complete it.

#### **iv) CONSENT**

I ..... agree that:

The aim or purpose of this research has been explained to me

I understand what taking part will entail

I understand that my participation is voluntary and that I can withdraw my consent up until the point described

I understand the anonymity and confidentiality aspects of this study and that my contribution might be identifiable.

I give my consent to take part in this study.

Participant signature

Date

Researcher signature

Date



## APPENDIX C The Sample of Volunteers

Volunteer	Professional experience	Situations drawn on in interviews	Details pertaining to involvement
1	14 years' post qualification experience within one service. Formerly Specialist Senior EP (Vulnerable Learners). Senior EP, and former colleague, at the time of study. In previous years (at least 5) has undertaken assessments contributing to multi-agency diagnostic assessments.	General, some specific casework examples	Involved from pilot stage so she provided feedback on the consent form, the oral briefing, and the interview questions, prompts and process and how she perceived me as a colleague she had known for a long time, although working in separate localities for over 5 years ( A 'challenging' / questioning colleague). Was provided with notes that I had transcribed but did not refer to them in between interviews.
2	14 years' post qualification experience within one service. Formerly Specialist Senior EP (Cognition and Learning). In previous years (at least 5) has undertaken assessments contributing to multi-agency diagnostic assessments. Undertaking locum work at the time of the study.	General and some specific casework examples	Involved from pilot stage so she provided feedback on the consent form, the oral briefing, and the interview questions, prompts and process and how she perceived me as a colleague she had known for a long time, although working in separate localities for over 5 years. Was provided with notes I had transcribed with my 'notes to self' about suggested areas to follow up in a second interview, which she did look at but reflected this approach was not helpful to her.
3	12 years' post qualification experience within one service. Specialist Senior EP (Cognition and Learning) and colleague at the time of the study. In previous years (at least 5) has undertaken assessments contributing to multi-agency diagnostic assessments.	One specific casework drawn for the most part of our talk, with some broader comments about roles and responsibilities of EPs	Transcript not provided in time as per explained process due to delays with the transcription service but this volunteer did not want to see transcript – EP commented that this would have distorted her process
5	Approximately 20 years' experience. Experience of at least 3 EP Services. Previously a Senior EP and with experience of University tutor role on EP training programme. Role of main grade EP with 3 years of experience contributing to multi-agency diagnostic assessments. Colleague at the time of the study.	An overarching approach to practice discussed	Had looked forward to the engagement with the research and from the outset of involvement, had considered the process a reflective space to indulge in that is not typically available in the course of work.
7	Approximately 5 years' post qualification experience not actively discussed. Relatively new to LA and being colleagues at the time of the study.	Drew largely on one casework example	EP viewed transcript from first interview briefly in advance of second interview, with interest as to 'how she had come across'. Felt transcript might be of further use for reflection, when she had time.
8	26 years' post qualification experience across a number of services and regions within England. A range of posts held. Special interest in language, autism, early years and complex needs. Specialist Senior EP post and colleague at the time of the study. Approximately 10 years' experience of contributing to multi-agency diagnostic assessments, including being EP service lead at the multi-agency diagnostic clinic.	Various casework examples drawn on with some thinking directed to recent examples and work strand which included work on attachment	EP engaged in a substantial activity in between her first and second interviews, and produced handwritten notes of a mapping activity indicating out how an attachment and autism presentations may appear differently, areas of commonality and suggestions about assessment.



Volunteers who consented but did not take part			
4	Relatively recently qualified Main grade EP New to being colleagues	Drew on one casework example in interview 1	Unforeseen circumstances meant EP was unable to continue beyond the first interview. Data not included for analysis as intended interview process not completed and unavailable to offer consent at time of submitting draft analysis chapter
6	Approximately 5 years of post-qualification across two services. Senior Practitioner role at the time of the study. Special interest in autism and experience of contributing to multi-agency diagnostic assessments. New to being colleagues.	EP volunteered and consented to involvement but did not take part	Following oral briefing and consent stages, EP did not respond to email inviting her to arrange a first interview and not actively pursued for engagement beyond this.

## Appendix D

Interview questions superordinate matrix: Volunteer 1 ('pilot' 1)

Social constructionist research aims	Purposes of questions / research Qs addressed	Broad questions	Specific questions
Situating research context and exploring identities of interviewer and interviewee	<p>a chance to re-visit consent? a chance to see where they are coming from?</p> <p>a chance to judge gaps between our expectations?</p> <p>a chance to equal the 'power' – admitting I'm new to interviews, but also introducing the idea that some aspects might be familiar to both of us?</p>	<p><u>Introductory Qs</u> You completed the consent form (? Date?). Thank you for volunteering to take part in my research. The 'what's in it for me?' I suppose is readily obvious – it'll help me complete my doctorate. Having taken part, I hope you'll have found it of intrinsic value. Have you had chance to reflect about 'what might be in it' for you?</p> <p>My idea about how this first interview proceeds is that I will ask open ended questions, with the aim of enabling participants to tell their story. How does this fit with what you were perhaps expecting?</p> <p>In my Masters research I used a written questionnaire which comprised a 5 point scale to elicit respondents' views. It was completed anonymously and I didn't ever meet the people (teachers) who responded. This approach feels like a very different one for a number of reasons: I am talking (not receiving responses via mail) and it is with known peers, not people I have never met. I am also new to using interview as a research technique. What experience of research do you have, either as a researcher or as a participant?</p>	Can I check that you continue to be happy to be involved? Is this needed since they have signed the form and are now sat there?
	a starter Q to elicit why they felt they might like to be involved, ascertain personal relevance?	<p><u>Initial open Qs (taking lead from Charmaz)</u></p> <p>So thinking about my research interest more specifically... EP practice when they are faced with a situation of considering whether Attachment or ASD might be a better interpretative framework for a child's presenting concerns How or in what way did this resonate with you?</p>	

	Situating the account in terms of professional identity and context	When did you first have an experience of working on this kind of situation?	So this was recent / a long time ago  What was it like FOR YOU working as an EP on this kind of situation at that time?
A social constructionist analysis would look to elicit participants' definitions of terms, situations, and events and try to tap into his / her (do we leave this tapping to chance or ask directly?) assumptions, implicit meanings and tacit rules (Silverman 2011)	<p><b>THEORETICAL / CONCEPTUAL</b> In making statements like these ("It looks more like attachment" in the context of a possibility of ASD) what do EPs mean?</p> <p>What do EPs say they mean in terms of their conceptual frameworks / models of ASD and attachment?</p> <p>In what ways are ASD and attachment constructed differently?</p>	<p>What was it like?</p> <p>What did you <u>think</u> then?</p>	<p>Would you be drawing on certain knowledge?</p> <p>Would you be drawing on literature / theory / concepts?</p> <p>How do you see attachment and ASD? In what ways do you consider them similar / different?</p>
To illuminate and make explicit EPs accounts of their practice in a prescribed area (when considering whether ASD or attachment is the most appropriate interpretive framework for understanding a C/YP 's behaviour)	<p><b>PRACTICAL</b> How do EPs go about tackling this situation?</p>	How did you happen to tackle that situation? i.e what did you <u>do</u> ?	<p>What does that mean I would see you do? What sorts of activity happens?</p> <p>Who else was involved, if anyone, and how were they involved?</p> <p>What happened then / next?</p>

To provide a dedicated space and opportunity for professional reflection	<b>IDEOLOGICAL</b> What core principles / values /ethics were at play?	How did it <u>feel</u> in that situation?	What influenced how you tackled the situation / chose to tackle the situation?
	Situating identity in terms of professional development and changing contexts	<p><u>Intermediate Qs</u></p> <p>Have you had further experiences since then? If so, how do they compare? Tell me what those (other) situations have been like</p> <p>Tell me about outcomes. How have these situations resolved or concluded?</p> <p>Tell me how your <u>approach</u> in regard to this has changed over time?</p> <p>Having had these experiences, what would you change / or do differently / the same?</p>	<p>Does your <u>practice</u> differ now?</p> <p>In what ways might your <u>thinking</u> be the same / different now?</p> <p>In what ways might your <u>feelings</u> be the same / different now?</p>
		<p><u>Ending Qs</u></p> <p>What would you tell / say to another EP who has not experienced to this situation?</p> <p>Is there anything / something else that you think it's important that I understand?</p> <p>Is there anything / something you'd like to ask?</p>	<p>This is our first discussion about your experience of these situations.</p> <p>Is there something else you feel important we capture at this point?</p>

## Appendix E

### Feedback from pilot interview 1 and reflections (discussion on 28<sup>th</sup> October about first pilot interview on 11<sup>th</sup> October)

Your feedback on the process of the interview would be valuable. I would use it to shape the design of the interviews. Please could I ask you to reflect in particular on the structure of the interview and the interaction approach adopted

How far did the interview structure enable you to tell your account?

Well structured, set type Qs. Zig zagging – would have preferred to be asked ‘how’ she did it, then look at a block of information, before unpicking ‘why’ it’s done a certain way. She felt because of the ‘zig zagging’ she forgot bits she wanted to say.

I had wondered:

- Whether zig zagging would be an inevitable part of the process and par for the course as ‘thinking’ (theory) and ‘doing’ (practice) were hard to keep completely separate – how to manage this in interview? Steer people back to the topic at hand (either doing / practice or thinking / theory) or follow the flow and zig zag? Perhaps an option might be to explain that there might be some zig zagging and ask how they would like this to be managed.
- Whether talking about ‘doing’ my help get the interview off to a smoother start anticipating it would be easier to talk about

How could I re structure my interview to enable you to tell your account more readily?

Would prefer to talk about what she does (practice) first – feels this would give me a different picture – ask about how you do the assessment – get this raw information and then challenge. Referred to Johari’s window – had felt she was consciously competent and then questioned herself about her practice – practices becomes ‘automatic pilot’, and then this (the interview) makes you stand back and think. Qs spark me off reflecting on what I was doing (reflective practitioner).

How far did the approach to interaction enable you tell your account?

Comfortable but zig zagging

Referred to her knowledge and understanding of me as a practitioner – sees me as challenging, in a way that she likes and that I am different in that regard (the only EP who challenges in a particular way). We spoke more about the ‘challenge’ in the context of our personal knowledge of each other and length of knowledge of each other. Says I always ‘push’ her to think ‘why’. Thought of ‘push’ being the same as ‘challenge’. She likes to be challenged (pushed / stretched) to justify her thought process.

I had not really appreciated how others might view me, but this was the second time this volunteer had referred to me being challenging. This aspect to my practice / approach had not ‘put off’ this person but I wondered that it might unduly interfere. Discussed how the interview pilots and feedback discussions were really helping me to clarify and articulate my intended role within the interviews - my aim of facilitating / enabling the construction of accounts, and I would hope / aim / intend to encourage people to explain as well

as describe: I would hope challenge to feel more like encouragement to expand and refine through probing and challenge not feel adversarial or negative (i.e. evaluative). She feels the 'social constructionist facilitator is there' but...

How could I adapt the approach to interaction to enable you to tell your account more readily?

Keep the semi structure

Keep the secondary questions – like the question “Is there something about...?” as this ‘puts it back on the other person’

Articulate the aim of the interview and my role within it, highlighting the probing for understanding but not evaluative nature of the research

Explain more up front about this being my area of particular interest and acknowledge that we might not share constructs but make explicit that where my interests lie – i.e. in understanding their account, and not in evaluating it. She also suggested including that information would not be feedback to management. We discussed what the limitations where to this as an ethics and proficiency based profession.

Ask more explicit questions up front to elicit their narrative before probing (for comfort for those who don't me perhaps so well)

Give permission to say 'I don't know'

Anything / Something else?

- More time to just speak from their extended narrative first (before discussion / challenge / probe)

As a lower grade EP – power imbalance a little bit threatening, could feel very different for a 2<sup>nd</sup> / 3<sup>rd</sup> year going through this process. Spoke more about what the challenge might feel like to someone who does not have the same knowledge of me, as her, and especially given my role at work, and years' experience how this might feel talking to someone with perhaps a couple of years of experience.

### To take away

- Keep some structure for direction and content re research questions
- Address power relations
- Highlight – non evaluative nature, the co-construction / facilitator intention, that we may share different constructs and practice
- Ask about doing first, for comfort, process, getting people talking
- Keep / have some secondary questions for probing
- Perhaps an option might be to explain that there might be some zig zagging and ask how they would like this to be managed.

## Appendix F

### Interview questions superordinate matrix: Volunteer 2 ('pilot' 2)

Social constructionist research aims	Purposes of questions / research Qs addressed	Broad questions	Specific questions / prompts
Situating research context and exploring identities of interviewer and interviewee	<p>a chance to re-visit consent? a chance to see where they are coming from?</p> <p>a chance to judge gaps between our expectations?</p> <p>a chance to equal the 'power' – admitting I'm new to interviews, but also introducing the idea that some aspects might be familiar to both of us?</p>	<p><u>Introductory Qs</u></p> <p>You completed the consent form (? Date?). Thank you for volunteering to take part in my research. The 'what's in it for me?' I suppose is readily obvious – it'll help me complete my doctorate. Having taken part, I hope you'll have found it of intrinsic value. Have you had chance to reflect about 'what might be in it' for you?</p> <p>My idea about how this first interview proceeds is that I will ask open ended questions, with the aim of enabling participants to tell their story. How does this fit with what you were perhaps expecting?</p> <p>In my Masters research I used a written questionnaire which comprised a 5 point scale to elicit respondents' views. It was completed anonymously and I didn't ever meet the people (teachers) who responded. This approach feels like a very different one for a number of reasons: I am talking (not receiving responses via mail) and it is with known peers, not people I have never met. I am also new to using interview as a research technique. What experience of research do you have, either as a researcher or as a participant?</p>	Can I check that you continue to be happy to be involved? Is this needed since they have signed the form and are now sat there?
	a starter Q to elicit why they felt they might like to be involved, ascertain personal relevance?	<p><u>Initial open Qs (taking lead from Charmaz)</u></p> <p>So thinking about my research interest more specifically... EP practice when they are faced with a situation of considering whether Attachment or ASD might be a better interpretative framework for a child's presenting concerns How or in what way did this resonate with you?</p>	P: tell me what you mean?

	Situating the account in terms of professional identity and context	To help us reflect, can we begin with a description of a recent case where you felt challenged to make sense of whether Autism or attachment themes were possible or competing interpretative frameworks?	<p>What was it like FOR YOU working as an EP on this kind of situation at that time?</p> <p>P: tell me what you mean? Can you give me an example?</p>
To illuminate and make explicit EPs accounts of their practice in a prescribed area (when considering whether ASD or attachment is the most appropriate interpretive framework for understanding a C/YP 's behaviour)	<p><b>PRACTICAL</b></p> <p>How do EPs go about tackling this situation?</p>	How did you happen to tackle that situation? i.e what did you <u>do</u> ?	<p>What does that mean I would see you do? What sorts of activity happens?</p> <p>Who else was involved, if anyone, and how were they involved?</p> <p>What happened then / next?</p> <p>P: tell me what you mean / can you give me an example – so I'm confident I understand?</p>
A social constructionist analysis would look to elicit participants' definitions of terms, situations, and events and try to tap into his / her (do we leave this tapping to chance or ask directly?) assumptions, implicit meanings and tacit rules (Silverman 2011)	<p><b>THEORETICAL / CONCEPTUAL</b></p> <p>In making statements like these ("It looks more like attachment" in the context of a possibility of ASD) what do EPs mean?</p> <p>What do EPs say they mean in terms of their conceptual frameworks / models of ASD</p>	<p>What was it like?</p> <p>What did you <u>think</u> then?</p>	<p>Would you be drawing on certain knowledge?</p> <p>Would you be drawing on literature / theory / concepts?</p> <p>How do you see attachment and ASD? i.e. how do you conceptualise ASD and attachment?</p>



	<p>and attachment?</p> <p>In what ways are ASD and attachment constructed differently?</p>		<p>In what ways do you consider them similar / different?</p>
<p>To provide a dedicated space and opportunity for professional reflection</p>	<p><b>IDEOLOGICAL</b></p> <p>What core principles / values / ethics were at play?</p>	<p>How did it <u>feel</u> in that situation?</p>	<p>What influenced how you tackled the situation / chose to tackle the situation?</p>
	<p>Situating identity in terms of professional development and changing contexts</p>	<p><u>Intermediate Qs</u></p> <p>Have you had experiences before this recent one(s)? If so, how do they compare? Tell me what those (other) situations have been like</p> <p>Tell me about outcomes. How have these situations resolved or concluded?</p> <p>Tell me how your <u>approach</u> in regard to this has changed over time?</p> <p>Having had these experiences, what would you change / or do differently / the same?</p>	<p>Does your <u>practice</u> differ now?</p> <p>In what ways might your <u>thinking</u> be the same / different now?</p> <p>In what ways might your <u>feelings</u> be the same / different now?</p>
		<p><u>Ending Qs</u></p> <p>What would you tell / say to another EP who has not experienced to this situation?</p> <p>Is there anything / something else that you think it's important that I understand?</p> <p>Is there anything / something you'd like to ask?</p>	<p>This is our first discussion about your experience of these situations.</p> <p>Is there something else you feel important we capture at this point?</p>

## Appendix G

### Feedback from pilot interview 2 and reflections (discussion on 20<sup>th</sup> October about second pilot interview)

Your feedback on the process of the interview would be valuable. I would use it to shape the design of the interviews. Please could I ask you to reflect in particular on the structure of the interview and the interaction approach adopted.

How far did the interview structure enable you to tell your account?

Yes it did but I felt I struggled with some of the questions at first – conceptualising (theoretical questions)

Is this to be expected as part of due process and therefore not necessarily anything untoward?

or does it reflect interview structure / Q

or does it reflect individual factors of the volunteer (redundancy / early retirement package 5 months ago, returning to work, and volunteering primarily to help me, not because of perhaps the same genuine desire for the topic as an EP who may 'sign up' for the research proper)

How could I re structure my interview to enable you to tell your account more readily?

Nothing comes to mind at this time.

Perhaps give some examples 1) it shines in the sky 2) it shines in the sky and its yellow. Can I do this as a co construction? Or would this be importing my ideas too early on? Does this reflect some discomfort about not giving 'THE right answers'?

Perhaps consider setting the scene at the start re how tricky / muddy this might feel. [M reflected on her MSc expectations (what she anticipated as a researcher) and the actual experience (in terms of trainee talking to experienced EPs) - how she felt / expected they would be able to talk about their work, and this wasn't borne out in the research process – EPs found it very difficult]

How far did the approach to interaction enable you tell your account?

Floundered at times – about what I wanted

Discussed the difference between a friendly ex colleague's experience and that of a current colleagues where I am a senior specialist

[How to re-assure colleagues about the non –evaluative nature of the research. Perhaps say more about my personal struggle to do the same / understand / articulate practice in this area - this may help manage the perceptions of power, their feelings taking part, their willingness to take part, feel comfortable)

How could I adapt the approach to interaction to enable you to tell your account more readily?

Make the 'muddy' a 'shared muddy' (explicitly)

To take away....

Expand scene setting to more explicitly address power / status issues of senior specialist, and now, supervising psychologist

Include some explicit reference about personal struggle on the topic under discussion

Expand the aim of the interview sessions as opportunities for co-construction – working together on shared muddiness and therefore on the approach to questioning / structuring the interview

There are no 'right' answers in terms of content – my aim is to get some content to each of the domains I'm interested in, and my role is to assist people to be able to reflect to deliver content

## Appendix H

### Interview guide

Interview Guide superordinate matrix incorporating feedback from the pilots

Social constructionist research aims	Purposes of questions / research Qs addressed	Broad questions	Specific questions / probes
<p>Situating research context and exploring identities of interviewer and interviewee</p> <p>Self- representation is directly 'outed' instead of remaining a white elephant'</p>	<p>A chance to re-visit consent?</p> <p>A chance to see where they are coming from?</p> <p>An opportunity to make explicit the potential 'power dynamics'</p> <p>An opportunity to re-frame the power dynamics - admitting I'm new to interviews as a research technique, but also introducing the idea that some aspects might be familiar to both of us?</p>	<p><u>Introductory Qs</u> You completed the consent form (? Date?). Thank you for volunteering to take part in my research.</p> <p>The 'what's in it for me?' I suppose is readily obvious – it'll help me complete my doctorate. Having taken part, I hope you'll have found it of intrinsic value. Have you had chance to reflect about 'what might be in it' for you?</p> <p>(From pilot feedback) In social constructionist research it is important to situate the research context, and included in this might be the relationship that exists between us as colleagues in the work place. As you know, I have the role of Specialist Senior EP and our working context has recently changed to mean that I have supervisory responsibilities within the team. My research process aims to be an egalitarian collaboration with peers. I wondered if you had any thoughts on this aspect of our relationship?</p> <p>I thought it might be helpful to share my thoughts on how we can approach this as a peer collaboration.</p> <p><u>A specialist senior yet also a novice:</u> In my Masters research I used a very different methodology to this study. It used a remote / anonymous approach to data collection using</p>	<p>Can I check that you continue to be happy to be involved? Is this needed since they have signed the form and are now sat there?</p> <p>I wondered what experience of research you have, either as a researcher or as a participant, and</p>

<p>The researcher as active in the interview process and as a co-constructor</p> <p>A constructionist view of interviews: Interview interactions are inherently spaces in which both speakers are constantly 'doing analysis' – both speakers are engaged (and collaborating in) 'making meaning' and 'producing knowledge'.</p>	<p>a chance to check for a shared understanding of the process from the briefing before beginning and set the tone / expectations / comfort of the interview</p>	<p>structured rating scales which were then subject to quantitative statistical analyses. This study uses a very different methodology on a number of fronts: it is face to face, it uses interview method, and the data analysis is qualitative. In these ways this research method is very new to me, and it feel somewhat unknown, as we don't know where it will take us</p> <p><u>An acknowledgement of my individual journey to conceptualising my practice and theoretical orientation.</u> As a specialist senior within the service, with a particular responsibility in the area of autism, and an interest in attachment, I can understand that colleagues might feel that I have particular expertise or knowledge, knowledge or expertise that you might not feel you have. I wanted to share that I am very much tussling with the specific research questions of this study myself and am really looking forward to our discussions. I believe that this process will enable me to also better construct my account of my practice, thereby gaining in perhaps similar ways to those taking part</p> <p>I explained in the briefing that this first interview is semi structured using open ended questions, with the aim of enabling colleagues to begin to construct an account of their practice. Our first discussion might take around an hour.</p> <p>Although there are some prepared questions, they serve as a guide, not a straitjacket. My experience from pilot interviews is that we might encounter some 'zig-zagging' across planned areas.</p>	<p>whether there were some ways in which you might feel like a novice too.</p> <p>I wondered what knowing this might mean for you and your thoughts or feelings about taking part.</p> <p>How does this fit with what you understood from the briefing?</p> <p>I wondered what your preference might be here – shall we zig zag, or would you prefer me to direct us to questions?</p>
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	<p>a starter question to elicit why they felt they might like to be involved, ascertain personal relevance?</p> <p>A check that colleagues have experience of, and beliefs about, the topic in question, enabling the researcher to gauge the potential orientation to the interview and enable the avoidance of leading questions that assume particular fore knowledges/ fore beliefs.</p>	<p><u>Initial open Qs (taking lead from Charmaz)</u></p> <p>So thinking about my research interest more specifically... EP practice when they are faced with a situation of considering whether Attachment or ASD might be a better interpretative framework for a child's presenting concerns How or in what way did this resonate with you?</p>	<p>Tell me what you mean?</p>
<p>Research would situate accounts in terms of professional identity and context</p>	<p>Situating the account in terms of professional identity and context</p>	<p>Tell me about the opportunity you have had to prepare for taking part in this discussion</p> <p>How did you decide whether or not to bring a case file?</p> <p>To help us reflect, how shall we begin? Shall we begin with a description of a recent case where you felt challenged to consider whether Autism or effects of attachment was the most suitable interpretative framework or shall we begin with thinking about these situations more generally?</p>	<p>I am keen to understand our starting point</p> <p>What was it like FOR YOU working as an EP on this kind of situation at that time?</p> <p>P: tell me what you mean? Can you give me an example?</p>

<p>To illuminate and make explicit EPs' accounts of their practice in a prescribed area (when considering whether ASD or attachment is the most appropriate interpretive framework for understanding a C/YP 's behaviour)</p>	<p><b>PRACTICAL</b> How do EPs go about tackling this situation?</p>	<p>How did you happen to tackle that situation? i.e what did you <u>do</u>?</p>	<p>What does that mean I would see you do? What sorts of activity happens?</p> <p>Who else was involved, if anyone, and how were they involved?</p> <p>What happened first/ then / next?</p> <p>P: tell me what you mean / can you give me an example – so I'm confident I understand?</p>
<p>To illuminate and make explicit EPs' accounts of their practice in a prescribed area (when considering whether ASD or attachment is the most appropriate interpretive framework for understanding a C/YP 's behaviour)</p> <p>A social constructionist analysis would look to elicit participants' definitions of terms, situations, and events and try to tap into his / her (do we leave this tapping to chance or ask directly?) assumptions, implicit meanings and tacit rules (Silverman 2011)</p>	<p><b>THEORETICAL / CONCEPTUAL</b> In making statements like these ("It looks more like attachment" in the context of a possibility of ASD) what do EPs mean?</p> <p>What do EPs say they mean in terms of their conceptual frameworks / models of ASD and attachment?</p> <p>In what ways are ASD and attachment constructed differently?</p>	<p>What did you <u>think</u> then?</p> <p>Would you be drawing on certain knowledge?</p> <p>Would you be drawing on literature / theory / concepts?</p>	<p>How do you define (describe) attachment?</p> <p>How do you see (conceptualise) attachment?</p> <p>How do you define (describe) ASD? How do you see (conceptualise) ASD?</p> <p>In what ways do you consider them similar / different? (aetiology, phenomenology)</p> <p>Can we explore the overlapping phenomenology as you understand it?</p> <p>What helps you problem solve when you encounter this overlap of phenomenology?</p>

<p>To provide a dedicated space and opportunity for professional reflection</p> <p>A social constructionist analysis would look to elicit participants' definitions of terms, situations, and events and try to tap into his / her (do we leave this tapping to chance or ask directly?) assumptions, implicit meanings and tacit rules (Silverman 2011)</p>	<p><b>IDEOLOGICAL</b> What core principles / values /ethics were at play?</p>	<p>We've talked about the activity (practice), the kinds of things you do, and we've talked about the knowledge base / literature / theoretical aspects you draw on or inform your practice.</p> <p>I'm wondering what else might have influenced how you tackled the situation / chose to tackle the situation?</p> <p>How did it <u>feel</u> in that / those situation(s)? Are you aware of having feelings around the problem solving process?</p> <p>Were there some aspects of the way you worked that felt very important to you?</p>	<p>We've mentioned parents, for example...</p> <p>(refer to other content that has emerged during interview).</p> <p>Topics from pilot interviews were: labelling versus diagnosis, ethics, EP role boundary, how parents are valued, how parents are protected, / treated, how parents are involved in problem analysis, the rights of children / young people), gains / costs of labelling/ diagnosis, the role of culture, responsibility for people's feelings / aftermath</p>
<p>Social constructionist research is interested in how things that are 'current' came to be, acknowledging that practice does not happen in vacuum but is historically, politically and culturally located</p>	<p>Situating identity in terms of professional development and changing contexts</p>	<p><u>Intermediate Qs</u></p> <p>Have you had experiences before this recent one(s)? If so, how do they compare? Tell me what those (other) situations have been like</p> <p>Have you a recollection of how this / some of these situations have turned out in the end?</p> <p>Can we capture something about how your <u>approach</u> in regard to this problem analysis scenario may have changed over time?</p>	<p>How have these situations resolved or concluded? What kinds of outcomes have they had?</p> <p>In what ways might your <u>practice</u> differ now? How has it evolved?</p> <p>In what ways might your <u>thinking</u> be the same / different now? How has it evolved?</p>



<p>A social constructionist approach to research would acknowledge that accounts provided in the here and now are always accounts of the past reconstituted in the present with the benefits of hindsight and with the failings / biases / distortions of memory Charmaz and Bryant (2011, 299 in Silverman 2011),“Interviews are of course, retrospective accounts that often explain and justify behaviour. Yet they may also be special social spaces in which participants can reflect on the past and link it to the present and future in new ways. An interview is a performance, whether stories tumble out or are strategically calculated and enacted, but that does not disqualify interviews from providing rich data and sparking analytic insights” (for both interviewer and interviewee I might expect?)</p>		<p>Having had these experiences, what would you change / or do differently / the same if you encountered this again?</p>	<p>In what ways might your <u>feelings</u> be the same / different now?</p> <p>In what ways might the context of local processes / procedures have influenced how your practice has evolved?</p>
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<p>A social constructionist approach to research would acknowledge that accounts are 'always' provisional</p>		<p><u>Ending Qs</u></p> <p>This is our first discussion about your experience of these situations and us beginning to construct an account of your practice, what and how you think, what you do, and how and why you do it and so on. By way of bringing us to a closure for today,</p> <p>What might you tell / say to another EP who has not experienced to this situation?</p> <p>Is there anything / something else that you think it's important that I understand?</p> <p><u>Looking forward</u></p> <p>This next steps of this research process are:</p> <p>That the interview will be transcribed</p> <p>That I will provide you with a copy of the transcription so that it aids your reflection on our discussion.</p> <p>That we both get the opportunity to annotate the transcription with things we would like to say more about, expand or amend etc and for us to check out that I understand what you mean.</p> <p>That we meet again and the purpose of this second meeting is that we use those reflective notes to continue constructing your account towards a fuller account that looks / sounds familiar to you. Can I check with you that you are happy for the next stage of the process to go ahead?</p>	<p>Is there something else you feel important we capture at this point?</p> <p>Is there anything / something you'd like to ask?</p> <p>Set provisional date for 2<sup>nd</sup> interview Book room</p> <p>Thank the volunteer</p>
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## **Appendix I**

### **Data Management - Transcription cover sheet**

**Participant identifier code:**

**Interview number (first, second etc):**

**Interview location:**

**Date:**

**Time:    to**

## Appendix J

### Data summary sheet

Volunteer	No of Interviews	Time period	Length of interview 1	Length of interview 2	Length of interview 3	Total talk time	Total transcript pages
1	3	11 <sup>th</sup> Oct-12 <sup>th</sup> Nov	54 m 31	1h 23m 25s	43 m 8s	3hrs 31s	21 37 20 (78)
2	2	20 <sup>th</sup> Oct- 12 <sup>th</sup> Nov	46m 43	1h 12m 24s	Na	1 hr 59m 7s	25 36 (61)
3	2	10 <sup>th</sup> Dec-7 <sup>th</sup> Jan	1h 08m 23s	1h 08m 46s	Na	2hrs 17m 09s	28 28 (56)
5	2	23 <sup>rd</sup> Nov-11 <sup>th</sup> Dec	1h 09m 34s	1h 26m 07s	Na	2hrs 35m 41s	32 35 (67)
7	2	1 <sup>st</sup> Dec-4 <sup>th</sup> Feb	54m 36s	56m 36s	Na	1h 51m 12s	28 29 (57)
8	2	16 <sup>th</sup> Dec-26 <sup>th</sup> Feb	1h 39m 51s	1h 24m 53s	Na	3h 04m 44s	43 27 (70)
	<b>13</b>					<b>14 hours 46 minutes 24 seconds</b>	<b>389 pages</b>

6 volunteers (including 2 'pilots')

2-3 interviews per volunteer

Overall, shortest interview 43 mins and longest interview 1 hour 39 mins

Total talk time per volunteer ranges from 1 hour 59 minutes to 3 hours 4 minutes

Nearly 15 hours of audio and nearly 400 pages of transcript

Range of experience less than 5 years to 26 years, approximately 95 years combined.

## Appendix K

### Cross Cohort Thematic Mapping (informing analytic choices)

Topic of talk / dimension / theme	Vol 1	Vol 2	Vol 3	Vol 5	Vol 7	Vol 8
Reflections on research process	*		*		*	
Reflection in action	*		*	*	*	*
Supervisory element of research process / value of research process	*			*		*
Supervision on the job					*	
Hopes for research process			*		*	*
EP identity (versus others)	*	*	*	*	*	*
Limitations of EP identity						*
EP role	*	*	*	*	*	*
Ethics / values / principles	*	*	*	*	*	*
Issues of labelling	*	*				
Politics / contexts	*	*		*		*
EP activity / theory	*	*	*	*	*	*
Conceptualisations of autism	*	*	*	None	*	*
Conceptualisation of attachment	*	*	*	none	*	*
Overlapping phenomenology	*	*	*	none	*	*
Cultural expectations	*					
Popularity of diagnoses	*					
Changes in diagnostic rates						*
Evidence of co-construction	*	*		*		*
Discourses / connotations of language used	*				*	
Value of decision making		*	*	*	*	*
Relationship between autism and attachment		*				
Interviewer role				*	*	*
EP feelings / place of emotion			*	*	*	
Effectiveness of EP involvement					*	
Practice as subconscious? EBP / PBE				*		*

Q how do EPs conceptualise ASD and attachment? Q do EPs see value in decision making / differential? Q how do EPs go about the activity of problem analysis? Q in what ways do EPs consider themselves uniquely positioned / skilled in this specific domain?

## Appendix L

Q1 How do EPs conceptualise autism and attachment? Thematic extracts from individual volunteers combined to enable cross case analysis.

Black – interview 1 Red – interview 2.

Dimension	Volunteer	Autism	Attachment
Definition	2	Problems of social interaction and communication and associated problems with language , flexibility, anxiety, emotional control, sensory issues, coordination, co morbidity (high levels of), attention control. In essence it's the brain, how the brain sees and organises the world (a medical model brain thing very much)	Manifests as difficulties with emotional and behavioural control as a result of not having had early secure attachments to a key adult but early experience does effect hard wiring of the brain. In essence its relational and emotional
	8	SCI presentation due to an understanding of / interest in reciprocity	SCI presentation perhaps because a child (who had predisposition to be interested) has given up being communicative / interactive based on experience of others lack of reciprocity – attempts are futile
Aetiology	1	Aware of a range of views – genetics, brain structure, toxicity / stress during pregnancy. Her view is that genes are the biggest component But feels that possibly some autism is confused with chromosome deletions	Significant separation from a significant adult in the first couple of years of a child's life. Prem baby – intensive treatment, multiple foster care placements. A lack of feeling safe with care givers or absent parents (physically or virtually speaking through mental health) leading to changes in physiological and brain function of the child i.e. leading to organic changes The organic component has been orchestrated through life events not from genetic endowment <b>life circumstances leading to brain make up (both biological and physiological)</b>
Aetiology	2	Both have a biopsychosocial model Genetic propensity triggered by the way you are brought up Genes have a larger part to play than environment Increased rates due to something in our environment triggering all sorts of anti- immune responses, not just better identification practices – there's got to be something about the way we live	Both have a biopsychosocial model Genetic propensity triggered by the way you are brought up Environment has a larger part to play than genes- Environment could include things like parental mental health, death and illness, and abuse , neglect
Aetiology	3	Has a neurological component but also an environmental role – how children are brought up (how those around them respond to them)	Significant role of parents with ability to form bonds and attachments during infancy (as decisive as no matter what child brings to the relationship, attachment is dependent on the care givers responsiveness) Temperament of child as a minor factor Early attachment versus developmental trauma as an explanation for

			difficulties seen within school, which aren't linked to a set period of time The early period is crucial but what follows is important as well
<b>Aetiology</b>	<b>5</b>	None discussed – the absence of these from her accounting explored - sees these conceptualisations as red herrings / distractions from EP role and activity	None discussed – the absence of these from her accounting explored - sees these conceptualisations as red herrings / distractions from EP role and activity
<b>Aetiology</b>	<b>7</b>	She doesn't think she has a clear idea about what ASD is. Understanding of autism / her conceptualisation is still evolving – based on a range of sources she's been exposed to.	Maternal mental health and dad's presence / absence: the child's experience of adults' availability, language in the early years, early developmental experiences, capacity to soothe / be responsive
<b>Aetiology</b>	<b>8</b>	Aware that research at that time (when parents were reporting and evidencing 'regression' in skills) indicated cause was not jabs but other explanation not given  Her view as slightly different to the accepted 'Public Health England view. "ASD isn't one thing, it's probably at least 10 totally different things. If you put a cocktail of chemicals into children, would you not expect a certain percentage of a population to react, those with a certain genetic predisposition? If there were a single cause for autism we would have found it and the cure"  An organic aetiology - brain processes possibly underpinned by physical / genetic factors that lead to dramatic lack of social interest, withdrawal from the world, sudden obsession or repetitive behaviour in the absence of other explanations i.e. no obvious trauma, no major illnesses, no terrible event	Infants who have been in intensive care Attachment themes /patterns rather than disorder Wondering about the distinction between effects of neglect versus an attachment issue Disruptions in early childhood, children not with their birth parents, prem babies – early experiences affecting current behaviour
<b>Theoretical</b>	<b>1</b>	In terms of presentation - Sees ASD as Social Communication, Social Interaction, Rigidity of thinking (triad) plus sensory	Does not describe presentation – only refers to aetiology  Refers to being aware of anxious and ambivalent types but that she would need to defer to 'trusty handouts' as this would be the weaker side of her knowledge
<b>Theoretical</b>	<b>7</b>	Still making sense of ASD and attachment and the purpose of them as 'categories' how we use them etc. acknowledges she hadn't considered her ideas about autism in a while.	Still making sense of ASD and attachment and the purpose of them as 'categories' how we use them etc. acknowledges she hadn't considered her ideas about autism in a while.
	<b>8</b>	Significant numbers of parents have reported to her, in her work, typical early development and then a change in presentation at a point in time (often around 14 months, and often around the time of jabs), parents remembering that their child just didn't seem very well or seemed to 'switch off' Go from sociable to rather passive (evidenced in home videos) Early social overtures may be lacking in ASD	early experiences affecting current behaviour  The child has the prerequisites to be sociable / for social connection (cooing/ babbling) SCI presentation due to has a child (who had predisposition to be interested) given up being communicative / interactive based on experience of others lack of reciprocity – attempts are futile  There needs to be (requires) 2 way opportunities for the development –

	<p>Her definition of the triad - She would have her 'triad' as 2 major things: social and flexible.</p> <p>Finds it easier to see social communication, social interaction and possibly social imagination as all related (instead of 2 parts of the triad conceptualisation).</p> <p>Her other major strand, flexibility, would include sensory (being able to integrate or balance sensory so as not to be over or under stimulated), desire for sameness, ability to predict / suggest alternatives (If A, then maybe B or C). Linear problem solving not multifactorial / complex (can't process more factors) a monotropism (Wendy Lawson) in thought processing of events and possibly also with sensory stimuli</p> <p>She makes a distinction between social and concrete imagination (social imagination fitting with 'social' and concrete imagination going with flexibility). The ability to weigh up and judge socially that is done logically / explicitly or intuitively to inform reasoned action</p> <p>Changes in diagnostic rates over the course of her career</p> <p>A historical perspective that is afforded by her age (and therefore her parents' ages) and length of service</p> <p>Explores reasons for apparent increase in prevalence in context of changes over the course of her career – in the beginning, EPs only saw 'classic autism' and many children were not in day care or nurseries (anyway, so why would they come to attention of EPs). Then, Aspergers became a diagnostic classification (appeared in manuals) and children increasingly attended settings (1974 Education Act – education for all children, not placing them in hospitals – Educationally Subnormal), and reduction in stigma in contrast to the openness of today probably all contributing to rise in diagnostic rates. Recounts parents' stories of 'crocodiles of children' (who weren't educated) who she was 'pulled away from' and a significant stigma existing</p>	<p>a child / infant with the prerequisites and a responsive parent, e.g. with preemie babies, you can have a parent on the outside who 'wants to get in'</p> <p>There might be child factors (like being anxious) but they've lacked 'good enough' opportunities to be noticed / responded to and the social or relational difficulties have a more reversible feel about them</p> <p>Unresolved disquiet about attachment – a work in progress, an ongoing musing</p> <p>Challenging thinking around 'accepted' knowledge</p> <p>Discomfort around requests for training on attachment because of the sense making by inexperienced people, the categorisations that go on and her unresolved qualms about attachment in general (a huge 40% is not secure, how can 40% not be 'normal', a monumental failure for / of evolution if 40% of parents get it wrong, the bizarreness of the Strange Situation Test,</p> <p>As an EP, tends to shy away from attachment because others tend to think of it in terms of disorder</p> <p>Feels she doesn't think about attachment as often as she maybe should</p> <p>Discusses how changes in her practice / understanding over time -</p> <p>How practical activity (focus at work) influences knowledge development</p> <p>Different developments in her knowledge base. Done very little in area of attachment post- graduation (1970s), whereas she feels her knowledge of autism has developed alongside her work, perhaps because her original interest was in children's language development. Feels if her work role had required it (had been around fostering / adoption, for example) she might have had more practical questions to address which would have meant her practice in attachment would have evolved, alongside her work practice, in the same way it did for autism</p> <p>Educational context of her teaching career. Packages promoted during her teaching and the theory underpinning those developed her understanding of language development and how this effected social development</p>
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## Appendix M

Q 2. How do EPs conceptualise the value of discerning autism from the enduring effects of early attachment experiences? Thematic extracts from individual volunteers combined to enable cross case analysis.

Black – interview 1 Red – interview 2. Green - Interview 3

Topic	Volunteer	Talk	Quotes
EP ethics – value of decision making and the down side of labels	1	<p>The pros / cons of decision making – the aim is always to improve outcomes for children, sometimes through proving or disproving, but always to work to achieve a better understanding, or provide strategies. When the end result is a diagnosis (ASD and attachment) 1) adults can re-appraise their practice now and in the future and 2) it can open doors to resources (in her particular authority)</p> <p>The unfortunate part about labels is not being able to access resources without them (when resources are diagnosis led)</p> <p>Labels and diagnoses can be helpful (and unhelpful) and interchangeable (re interpreting a child, supporting provision and strategies)</p>	<p>Because I've constantly got the child at the forefront. The child is my <i>client</i>, for want of a better word. I'm <i>working</i> to make things <i>better for that child alongside</i> all the other people that are involved. I'll <i>advocate</i> if I think it's necessary. I'll do the assessment, if I think it's necessary, or talk to the child. Do you know what I mean? Yeah.Yeah. And, well, and that's interesting, isn't it, so [pause] adult A, B or C can sign the form and ask for the input. Yeah. So they're the <i>commissioner</i>, Uh huh but in <i>your mind</i>, Hmm <i>your belief system</i>, it's the child you're working for, not the person who's asked for the...? I will <i>answer</i> their question, [pause] but <i>ultimately</i>, I'm looking to improve the outcomes for that child. [pause] And if that means I prove or disprove, that is what I do, but I will <i>always work</i> to give a <i>better</i> understanding and or strategies, or training, <i>whatever</i> it is.</p> <p>So do you see <i>inherent value</i> of coming to some sort of conclusion with this dilemma? It's this or it could be that? Do you see that there is a <i>purpose</i> in maybe coming off the fence or...Yeah....that it's a <i>worthwhile</i> problem to tussle with? Yeah.</p> <p>[pause] <i>Because</i> you believe it has direct implications...Yeah, because, if if [pause] if the <i>end result</i> is an accepted diagnosis of, for example, autism Hmm for that child, and then the people who were <i>involved reappraise</i> their practice and <i>think</i> about what it is that they're going to do in the future, then that has had a positive outcome. But, <i>equally</i>, what I will say is, during the consultation, for example, we can put these strategies in <i>now</i>, and we <i>should</i> be putting those strategies in. We shouldn't have to wait eighteen months. We can do that. But what it will do is <i>help</i> people <i>further</i></p>

			<i>down the line as well</i> understand what is going on, in some cases it opens up a <i>whole new set of doors</i> in our authority, because without your diagnosis you can't access more specialist teaching, without your diagnosis you can't do this, you can't do that. Erm and that's the unfortunate part about labels, isn't it?
<b>The place or value in coming to a differential decision</b>	2	There is inherent value in working out 'what's what' to determine what is actually working best / might be the best approach / strategy but you don't need the diagnosis to do that and there are caveats (down sides to labelling)	
<b>is a label a hypothesis</b>	2	Label – it is (said definitively) Hypothesis – it could be...	
	2	Role / influence of cultural values on how / what we expect of children's behaviour	
<b>Pros and cons of labelling</b>	2	The autism label as emotive Labels as tickets to support in school / during education Could promote negative or positive self-perceptions in young people (some very enthusiastic and keen to have their differences acknowledged, some very happy and confident)	
	2	On the positive side – access to resources to help, and might help an individual understand their situation better (move forward in themselves, helps parents deal with situations better). On the negative side, it has long term implications – stuck with it for life you wouldn't get rid of it any time soon. Not a great fan of labelling – you could get the same understanding through a hypothesis (as a formal label / not a full on 'written in stone in a medical file')	
<b>Disquiet about the way systems work (counter to her professional comfort zone)</b>	2	Open the money door and everybody swings into action (a business? – labels equals resources – diagnosis led provision)	
<b>Access to provision expectations</b>	2	Setting up expectations of parallel (comparable) support in adulthood that isn't necessarily available, like it can be in schools	
<b>The problems of labelling as a catch all</b>	2	How do you sum up somebody's whole way they are, on one particular aspect?	
Questioning potential benefits of attachment diagnosis	2	Would rarely refer for a diagnosis of attachment and questions the gains of a diagnosis – what would be the benefit?	
Benefits of attachment diagnosis	2	A 'ticket' to get certain people working with you, and a framework for understanding (of adults involved)	
<b>Labelling versus diagnosis – shared</b>	2	The word label has featured a number of times in her account – trying to check out with her whether it is the same or different to diagnosis in her	

<b>meaning? Uses of terminology</b>		<p>view (versus my), in particular when it is said alongside words like tickets and phrases like 'the money door is opened and everyone swings into action – as if they were inert beforehand)</p> <p>In her view she uses label and diagnosis to mean the same thing, and children and families see it as the same thing (indicating a within child thing)</p> <p>Labels – tickets, money doors, swinging into action – in order to access resources (a 'licence to print money', slapped on willy nilly?)</p> <p>Diagnosis – informed through rigorous professional assessment, in order to inform appropriate treatment / intervention plans</p> <p>He was labelled with pancreatic cancer versus he was diagnosed with pancreatic cancer</p> <p>In practice - Do people treat the words label and diagnosis in the same way?</p> <p>In theory - in a theoretical sense, do they have quite different connotations?</p>	
<b>EP role end goal</b>	3	<p>The end goal of EP involvement is to meet needs rather than give things a name</p> <p>EP's role is not to diagnose or be a gate keeper</p>	
<b>Best fit</b>	3	<p>To identify a best fit – which is not the same as a compromise or second best – people don't fit neatly into compartments</p> <p>Contextualised assessment based on range of sources of information</p>	
	3	Priority is supporting staff to support the child	
<b>EP role end goal – diagnosis versus meeting needs</b>	3	The end goal of EP involvement is to meet needs rather than give things a name	
The value place of either / or hypotheses / decisions in her work	3	Sees self as an EP more of an onlooker of ASD assessment (as she is not part of the formal diagnostic assessment) or that an ASD assessment ongoing was secondary to what she was doing in her role of supporting staff	
	3	Pursuing a diagnosis of ASD in this case she felt was a red herring / taking people's eye off the ball (as her / camhs view was of attachment)	
<b>Pros and cons of diagnosis</b>	3	When staff see ASD as a within child problem (something wrong with him), it could release them from responsibility from doing anything about it to support him	
Differences versus disorder – clinical thresholds	3	Unpacking disquiet about labelling / diagnosis and to what extent some children really have 'clinical impairments'. The early identification agenda encouraging people to examine differences that might just be that, 'differences' in the normal population	
The overall place of labels – attachment and ASD	3	There does not necessarily have to be a label at the end of a piece of EP work – whittling down to find reasons / explanations for behaviour does not necessarily mean it has to be named something (that is diagnosable /	

		considered disordered)	
Value of diagnostics and decision making  Diagnosis as a distraction from pragmatism of helping in the here and now	5	Diagnosis often not important, she looks at what can be done A diagnosis might be somewhat of a red herring and does not affect her work, and she operates within the principle of 'do no harm'  'a little by the by'	
labelling	7	The pressure from others to label Turmoil / frustration arising from conflict Tensions created by role expectations	
EP activity / role	7	Observation, supporting staff initially, then became more about supervising school staff. EP role shifts with shifting priorities as involvement progressed / time passed and circumstances changed. EP role not static. Overarching end goal might be the same (remain constant) (child outcomes) but direct immediate site for intervention / action might change  Advocate for child Containing the containers" – supporting staff to manage their feelings	
EP role / goals / outcomes	7	Placement maintenance: prevent placement breakdown, by containing staff and easing distress of child	
The place of differential diagnosis not predominating – this took a back seat. Could have both roles (looking at causes and supporting presenting needs)	7	To prioritise a course of action at a particular point in time (to meet presenting need, not identifying causes, given the level of challenge presented) but which is presenting as a priority (and how best to use limited time)	
Being distracted from hypothesising – original / preferred activity / role	7	Focus of involvement /activity shifted over time as the situation progressed and information came to light	
Is it possible to hypothesise whilst having a supportive / containing function	7	Withdrawing from staff as post ended allowed a renewed focus on hypothesising (perhaps suggesting that even though she has expressed disquiet – hypothesising, if not labelling / diagnosing, is something that she sees as worthwhile / a primary focus when circumstances allow	
Can you maintain perspective if you are in	7	Birds eye view ? suggests not intertwined (allows hypothesising) or being 'in and amongst staff' (containing) – the latter valued by staff versus perhaps	

and amongst?		what her initial (preferred ?) role was	
Place of hypothesis generation	7	When it goes to EHC assessment, the hypothesis becomes important as provision matching related to / links to labelling / diagnosing / hypothesising when provisions / resources are diagnosis led	
Value of labelling / diagnostic activity / EP identity	7	This EP values 'support in the here and now' versus effort / energy on diagnosis. The idea that diagnostic assessment work (1) detracts from solution oriented practice in the here and now (seem mutually exclusive rather than co-existing) (2) lacks utility (3) removes responsibility. Support is the same irrespective of label	
EP versus non EPs contradictions in expectations ?????resisting?????	7	EPs wanting to work at a pace that's appropriate for due process versus non –psychologists wanting a result  The time pressure (suggestion of pace) of others' expectations '(all these other people i.e. non psychologists) are waiting (suggesting passivity on their part?) for <u>the</u> (suggestion of linear / singular cause) <u>answer</u> / outcome / result (i.e. 'name for it')  EPs wanting to engage in a process (of wondering and being curious) and sitting with a problem i.e. her comfort zone of practice versus what others want	
Role expectations / pressures on her activity (choices / decision making)	7	To diagnose with a clear answer as to what is and why a child behaves that way	
	7	Expectations as to the kind of activities she should be undertaking to fulfil other peoples' expectations of her role	
Tensions / conflicts / role expectations/ EP identity	7	Others views that she would diagnose / give a label – she does not see herself as a psychologist in this way / not her role	
EP values / principles	7	Determining what is in the child's best interests in terms of focusing her practice: in this context, what can she do that is of best value / least detriment to him? Duty to the child (1) – child specific factors in the context of the others involved (contextual factors) determines legitimate sites of intervention / activity	
EP values / identity Autonomy in professional decision making	7	Bending rules, stepping outside of protocols and established ways of doing things, judgement calls, permission giving, flexibility in order to: 1) sit with emotions, hold feelings, listen and think and thereby 2) avoiding forced reactivity, aimless work / activity and other's pressurising expectations	
EP decision making	7	Decisive / taking action based on interpretation of information gathered / shared	

Accountability, defending a position. Decision making / position taking in a context of pressure and accountability	7	EP being clear of her view, when it is a solitary voice in a context of scrutiny / recording that is meticulous – pressure of being heard, safe in your decision making versus how other professionals practice	
<b>Tension for EP activity in context</b>	7	Provision is matched to diagnosis (cause), not presenting need, so a tension if EP activity is / has been focused on need (not causality) – what if LA is also a customer – what would they expect the EP to help them do?	
Evaluation / appraisal of activity in the context in which it occurred	7	What is most helpful in <u>this situation</u> , at <u>this time</u>	
Value of diagnostics and decision making	8	You don't always need to know / decide 'where it comes from' or reach a conclusion to make the next step– you need to know enough to identify difficulties and an area people want to work on	
	8	Dangers of misdiagnosing – provision that is inappropriate and self- limiting	
Safeguarding / Long Term implications of labelling	8	The long term implications of labelling, perhaps LD, and how 'labels' might affect perceptions of capacity for change. 80-90% of adults (parents) who have 'Learning Disability' who enter safeguarding, end up having their children removed from their care.	
	8	The complexity yet importance of working on / working out 'what it is' and trying to get some distinctions – so people don't get the wrong labels	

## Appendix N

Q3 Part b How do EPs conceptualise their problem analysis processes? Thematic extracts from individual volunteers combined to enable cross case analysis.

Black – interview 1 Red – interview 2. Green - Interview 3

Dimension	Vol	Talk	Quotes
EP theory – psychological influences	1	CAF / Bronfenbrenner (family friends environment situation school, risk resilience factors) Human Givens factors to be considered about how a child's basic needs are met (process this) before searching for diagnoses /diagnostic explanations. Thinking psychologically about the whole child	
EP activity Thought process	1	An analysis of factors should proceed an interpretation – lead to an interpretation, not done quickly, not done instantly	
EP activity Thought process	1	A process of unpicking over time (a bit at a time)	
EP activity thought process	1	Begin to formulate initial hypotheses, piece things together. Explore information in detail i.e. initial hypotheses are subject to change	
EP activity thought process	1	'connecting the dots' but being careful not to make assumptions whilst doing so	
EP activity Thought process	1	Look at 'what else' before thinking ASD (unless it was immediately obvious)	
EP activity Thought, practical and reporting	1	Overall, explore that basic needs are met, explore contextual factors (systems psychology), EP work and subsequent report should be structured in a specific way, for a specific purpose, by a specific audience	
EP activity – thought, practical and reporting	1	Comprehensive cross referencing and triangulation, use of peer supervision as a sounding board, extensive information gathering around life circumstances for clues as to other reasons for anxiety / anger, co-work with other EPs	
EP activity – problem analysis activity cycle in tandem with analysis and interpretation	1	Observation in class, 2) observed at lunch 3) Qaires 4) discuss Qaires 5) 1:1 work 6) meet parents with interpretation going on all the time throughout this process. Content depending on individual pupil factors	
EP activity – problem analysis cycle in tandem with interpretation	1	Iterative process of visiting steps / activities to clarify /check for consistency, look for exceptions (re-visiting) listening for clues that present through exploration, not necessarily pre-set / pre-determined Qs	

<b>EP activity</b> <b>Who else involved</b>	<b>1</b>	Discussions with adults / carers, parents, SALT / CAMHS if they are involved	
<b>EP activity</b> Practical steps	<b>1</b>	<u>Observation</u> in a range of scenarios in school (break, lunch, class), use of actual and mental checklists / aide memoires, note taking (of interaction, communication, stereotyped and repetitive behaviours / sensory	
<b>EP activity</b> Practical steps – ASD specific	<b>1</b>	<u>Direct work with child</u> to explore their understanding of facial expressions, their ability to take part in conversations with reciprocity, sequencing – all dependent on age of child	
<b>EP activity</b> Practical steps – attachment specific	<b>1</b>	An attachment behaviour questionnaire (with 4 types of behaviour) to be used in a dialogue with school staff, and probably parents to see if there were issues	
<b>EP activity</b> attachment specific	<b>1</b>	A priority for attachment is to look for early clues / pointers in early history	
<b>EP activity</b> attachment specific	<b>1</b>	Would look to liaise with SALT if querying ASD but not if querying attachment	
<b>EP activity</b> Overlapping phenomenology	<b>1</b>	Coventry Grid to map out areas of cross over (if on the attachment framework it looked like the pattern that mirrors attachment)	
<b>EP activity overlapping phenomenology</b>	<b>1</b>	Coventry Grid out – to use in a conversational type approach	<p>Er Okay. So this about how you see attachment and autism,</p> <p><b>Uh huh</b> and ways in which you think they might be the same or different, and you've talked about a particular strand, about managing change. So if we had [pause] our attachment list here of what that looked like, and we had our autism assessment here and what that, what autism, your ideas about what attachment is and what it looks like. So it looks like this, this and this. <b>Hmm, mmm.</b> And we had similar for your conceptualisation of attachment. <b>Hmm, mmm.</b> The tricky bits, the bits that you're trying to unravel in the middle, the <i>overlapping phenomenology</i>, can we say a bit more about what you think, we've got in here resistant to change, [pause] or coping with change, did you say <i>managing</i> change? <b>Yeah.</b> Is there anything else that would go in that middle [pause] block? What else is sort of shared territory that needs unpicking? [pause] And to decide whether we're going to put it in this camp or put it in that camp? <b>Off the top of my head, I would say I would get my Coventry Grid out.</b></p> <p>So that is where you would use...? <b>That's where I would use my Coventry Grid.</b> [pause] And I would use</p>



			[elongated] <i>that in a conversational type approach as well.</i>
<b>Assessment</b>	<b>2</b>	The value of history (taking) is important in differentiating	The value of history (taking) is important in differentiating
<b>EP tools / activity</b>	<b>2</b>	Coventry Grid – comments it is an interesting framework but less clear about how useful it is	
EP activity informed by contextual factors including individual pupil factors influencing choice of approach	<b>2</b>	Observation Consultation with various people Direct work – that might be autism relevant (faces / eyes test, comprehension, use of language , play and shared play) Use of frameworks Avoids / dislikes questionnaires Explore the family situation	
Sequence to activity	<b>2</b>	Observation / 1:1 work / consultation order could vary according to situation specific factors, but does not do assessment before observation and observation before consultation is her preferred order	
Factors influencing specifics of practical activity	<b>2</b>	Various factors influencing practice. Lots are practical, some are theoretical (e.g. age of child), some are professional judgement calls (seen what I need to see in 20 minutes)	
Factors influencing specifics of practical activity	<b>2</b>	Observations are free hand – logs things that occur as they occur Writing is organised into sections to collate comments against themes	
How to write	<b>2</b>	Writing into a mental structure which might include sections on social interaction, flexibility where observational features are lifted into those sections	
Factors influencing specifics of practical activity	<b>2</b>	The bigger picture / overall agenda and time constraints - what's the job? How long have I got? (Including time bought by school) all influence choices made.	
triangulation	<b>2</b>	Triangulation in EP assessment information with those that know the child well to gather a fuller picture	
Testing hypotheses	<b>2</b>	Make suggestions for intervention during consultation and see the effect those interventions have	
Assessment over time	<b>2</b>	Assessment over time is ideal – to assess responses / test hypotheses	
Looking for patterns	<b>2</b>	Looking for a pattern in all of the data gathered – ‘putting a picture together’, looking at the whole	
Keeping an open mind	<b>2</b>	Consider alternative hypotheses	
Mindful of complexity	<b>2</b>	Be aware of the huge complexity of environmental, social and genetic factors	
Across her activity – she keeps aware / foreground of practice	<b>2</b>	Keeping an open mind, consider alternative hypotheses, acknowledge the huge complexity of factors	
Explore the Coventry	<b>2</b>	Gives reasons / explanations of things that look the same rather than actual differences to	

<b>Grid and EP decision making</b>		look out for, which might be more decisive. The Grid has not provided any solutions or any ah ha! Moments. Describes it as interesting but less helpful – an honest attempt to disentangle (the reasons behind) but not in the dissecting of observable behaviour. Suggests it would be naïve to expect the Grid to give answers or definitive ‘swing evidence’ (note to self, do other services e.g. CAMHS expect questionnaires / grids to give answers as current practice heavily in favour of data collection via postal paperwork, not direct informed observation or dialogue with those reporting?)	
<b>Culture in decision making</b>	2	Influence of cultural factors in decision making – cultural expectations / norms, for example in an African culture	
	2	Exploring the family situation looking for what reasons there might be for an attachment issue	
<b>Coexisting conceptualisation ASD influencing the development of attachment</b>	2	It does not necessarily have to be either / or and there is some interaction. It can be difficult for parents to attach well sometimes and then it becomes very difficult to disentangle	
<b>Overlapping phenomenology</b>	2	The degree of inflexibility in an individual’s outlook (and the style in which that is communicated) might not best be accounted for by attachment – ASD might serve as a better explanation	
	2	No two children are the same – look for a pattern across a number of areas (see separate sheet)	
	2	Features are not mutually exclusive – need to look at the whole	
	2	Detailed History required in both cases to rule other things out and help with decision making around causation and even coexisting	
<b>Pointers</b>	2	There are some things that make deciding ‘obvious’ - American accent as an obvious ‘feature against the non –attachment’ decision making	
<b>Pointers</b>	2	Other obvious pointers would include flapping and licking his hands	
<b>pointers</b>	2	Idiosyncrasies of language more ASD than attachment	
<b>pointers</b>	2	Play in attachment might be more imaginative than in a child with autism because imaginative play can be really hard to see because what appears imaginative maybe something copied off the telly, and they may do it every day.	
<b>pointers</b>	2	Play, new experiences, lack of skills sharing / communicating,	
3 elements of EP activity	3	<ol style="list-style-type: none"> <li>1) Assessment including observation and talking to staff (to generate strategies / hypotheses)</li> <li>2) Supporting staff / containing their emotions over time and supporting them to develop their thinking</li> <li>3) Multi- agency meetings – the site of some controversy</li> </ol>	

EP sources of information synthesised	3	Hypothesis generation over time through activity, with sources of information ( <u>gleaned</u> – incidental, <u>gathered</u> – actively sought and <u>observed</u> – directly witnessed)	
EP activity – logical activity with reflection	3	Being open minded to try / test various ideas in a logical manner, with reflection and interpretation / consideration of all possibilities in a process rather than coming to conclusions soon - (reminiscent of PAF)	
EP activity – logical activity with reflection	3	Being open minded to try / test various ideas in a logical manner, with reflection and interpretation / consideration of all possibilities in a process rather than coming to conclusions soon - (reminiscent of PAF)	Well, I think I would encourage them to <u>reflect well</u> , because I think that is important. [pause] Take time to reflect on what, I mean, in some ways that's standard EP practice, isn't it, but I think I would <u>remind</u> people to do that, that, okay, "So look at what you, always take a very <u>logical</u> approach, which is, 'What are you seeing?', 'What is presented in front of you?', and then do that <u>process</u> of, so 'What <u>could</u> it be?". So, rather than <u>jumping</u> at something <u>straight away</u> , "What are <u>all the different things</u> it could be? Is it developmental?, Is it neurological? Is it environmental?, is it der, der, der, and if this is the behaviour we're seeing, what, <u>why</u> might we be seeing that behaviour, what could be underlying that?", and having <u>all</u> the possibilities, if you like, <u>and then</u> doing that <u>whittling down</u> in terms of, "Okay, then go back to some key information, text, whatever you like, to say, tools, to say, "Right, okay, so how does this fit in with that?", and I do often think it's about a best fit in these situations
Best fit	3	To identify a best fit – which is not the same as a compromise or second best – people don't fit neatly into compartments Contextualised assessment based on range of sources of information	
The trickiness of this particular hypothesis generation / problem analysis	3	Contextualised assessment is needed because of the absence of a standardised assessment for ASD – 'assessment' / conclusions are based entirely on interpretation of observable behaviours	
EP role / goal	3	Priority is supporting staff to support the child	
EP role / goal	3	EP's role is not to diagnose or be a gate keeper	
EP role / goal	3	The end goal of EP involvement is to meet needs rather than give things a name	
EP work / involvement / activity is not static – it's context dependent and contexts shift.	3	How EP involvement, evolved over time (plan-do-review, assessment, consultation re strategies	
Hypothesising /	3	The role of a precipitating incident in relation to an escalation – contextual factors	

theory			
Hypothesising / theory	3	EP's interpretation / observation of mum's presentation (Highly anxious) – family matters / relations. EP's view of mum versus other mum's of children with ASD. 'Can manage him by... (typical of parents of children with ASD) versus 'I cant manage him' (more typical when issues are relational / attachment based)	
Interpretation of broad picture / overall trend	3	Seeing an overall trend, understanding or evaluating / interpreting specifics in a wider context of overall picture	
Solution focused	3	The use of solution focused principles to move a situation forwards (from problem talk)	
<b>Overlapping phenomonology</b>  Within child factors in problem analysis	3	Anxiety created need for predictability (what's coming next, prep for transitions – rigidity was about control and managing anxiety). When calm (not highly distressed) could hold a conversation, didn't want to talk about his own interests all the time, was able to apply learning to different contexts, appropriate interaction when calm, he wanted friends	
<b>Features that are missing as illuminative (more helpful?) when ruling ASD in / out</b>	3	Areas covered (of an ASD profile –does she mean triad?) and areas not covered – about what is there, and what is not there: absence of these areas could be more attachment – no obsessive interests, no difficulties understanding humour, no difficulties with social interaction when calm, no funny voices (accents?), no set phrases,	
What helps problem analysis	3	1)The difference between observable behaviours and their explanations / underlying reasons (and would these be different) interpretations 2) the spread of evidence across the triad 3) what else is and isn't there – look for areas covered / not covered	
EP hypothesising / formulation	3	An active appraisal / interpretation of the overall picture of what is seen and what is not seen rather than specific features readily fitting into one camp or other by putting things into the context of other things seen or known	
<b>Role of theory in problem analysis</b>	3	Use of theory to assist in differential hypotheses ' problem analysis (Louise Bomber, ASD questionnaires, key texts)	
<b>EP problem analysis in logical steps, one thing following on from another</b>	3	Likes to work in logical steps, so chronology is important, first this, then that	
<b>Best fit</b>	3	Problem analysis as a best fit in a world of cross overs – the overall picture	
<b>Contexts which impede or smudge an EP's ability to work logically in a planned and preferred way</b>	3	The contribution of some school staff (on behalf of mother) as derailing / side tracking, at times, an approach that otherwise had started off following logical steps – so EP activity effected by the behaviours of others.	
Differences versus disorder – clinical thresholds	3	Unpacking disquiet about labelling / diagnosis and to what extent some children really have 'clinical impairments'. The early identification agenda encouraging people to examine differences that might just be that, 'differences' in the normal population	

Cultural expectations	3	About what is normal (home / family expectations and school expectations) versus ethnic expectations	
EP ethics / responsibility to voice professional opinion which is grounded in theory	3	EPs are responsible for saying what they think	<p>Is there anything else, [name] that you would think is important that we capture? <b>Anything else?</b> [long pause] Yeah, maybe one thing about talking to EPs, and that is, we <i>have</i> to listen to others and, obviously, respect what they say, that's important and I feel very strongly about collaborative work and partnership working, but at the <i>end of the day as well</i> [pause] we we sometimes have to put ourselves on the line and we have a professional responsibility to say what we think, and that's actually a lot of what we get paid for. Hmm</p> <p>And therefore [pause] not to shy away from that, [pause] because it would be very easy just to describe what's going on, [pause] lots of people describe what's going on and they come up with a few strategies, but it's that <i>middle bit</i> of saying, "So what you see, what's going on", and you need, and I think that's where I've got to, I'm saying about that <i>confidence bit</i>, <i>it is around</i>, you know, the world isn't going to go under your feet [laughs] if you say something and someone disagrees with you, but on the whole, most of the time, probably not, people won't disagree with you anyway. Er you <i>do</i> have to take that professional responsibility, and I think that's important, because for me that's, because there are times when I think, "Well, that person could have come up with that, but I'm getting paid twice as much as them". The reason being is that, actually, we can say <i>why</i> we've suggested that,</p> <p>Hmm base it in theory, but also we'll be the one in the meeting who said, "We think that...". I don't know whether you've come across that 'Oh well I wouldn't like to say', you know, and everyone looks to you as the EP because they want <i>you</i> to say it, and that's one of the responsibilities that we have, I think, Yeah [pause] which, so you've got to put yourself out there sometimes [laughs] to say what you believe, and as long as you've done all your reflecting, and thinking, your referring back, you know, and you can justify...And so we've kind of come full circle <i>back</i> to the identity of an EP, Yeah</p>

<p>EP activity</p> <p>Building trust Creating space Process over time Explores story Re-frames story – to change others' views Generates understanding/ hypotheses Collaborative action planning</p>	<p>5</p>	<p>Building trust Creating space Process over time Explores story Re-frames story – to change others' views Generates understanding/ hypotheses in a way that avoids latching on to quick explanations or being blinkered by diagnosis takes a pragmatic approach, keeping an eye on emotions of those taking part a consultation process (which includes labour intensive preparation) in a safe and protected space involving joint consideration by relevant parties (described as an in depth emotional consultation) A process that peels back the layers and clarifies current issues Asks questions from the early years to unravel a story from conception and birth (includes child's developmental history, significant events, parents' wellbeing and other siblings) to inform a broad understanding of the child's understanding of the world Mapping an emotional developmental history Listen out for terminology and how YP are described Asks adults to take a sideways step to see the CP from a different angle and to interact differently The intended outcome is for others to see YP differently Significant life event history, including relations between parents and between parents and school setting A first meeting that is 1-1hr 15 minutes (ish) Which includes a phase of summarising 3-6 key points (academic, social, emotional wellbeing, physical / medical) to inform a plan of helping (purpose of which is to generate /articulate hypotheses and begin to consider 'what next?') Give others tasks in the action plan To ensure the child is 'held' (literally and metaphorically) during the parental separation Dual purpose – gain parental trust and staff engagement through better attunement / affiliation Ending the session – agreeing how / when to review The ending of a piece of work is when the main part of her job is done i.e. an understanding is generated and an action plan is in place for others to maintain Doesn't do observation – doesn't understand why or how its helpful Balance of EP activity: focused, sapping work (2 at most in a session) with rest of time spent ( comparatively) 'playing' – building relationships (to fuel and add to the working relationships within the school that allow the/ give the permission for use of EP time for the intense work)</p>	<p>The aim of her work is not to unravel ASD or attachment but to reframe to a strengths based perspective and make an action plan</p>
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Her account of her work versus my planned Qs – how is that addressed between us in the research process? Discussion about theories implicit and explicitly drawn upon	5	Discussion about planned / intended exploration (re research questions) about conceptualisations of autism and attachment and overlapping phenomenology – as not relevant to her activity, which draws on a different set of psychologies Long section of talk about her psychology without naming it, but suggestions made (attachment, psychodynamic, systems, narrative, transactional and script analysis) which are met with agreement and then explicit reference to transactional and script analysis informing her thinking	
EP activity / role	7	Observation, supporting staff initially, then became more about supervising school staff. EP role shifts with shifting priorities as involvement progressed / time passed and circumstances changed. EP role not static. Overarching end goal might be the same (remain constant) (child outcomes) but direct immediate site for intervention / action might change	
EP role	7	Advocate for child “Containing the containers” – supporting staff to manage their feelings	
EP role / activity	7	Talking things through, reflect back with people, have a space to get some distance. Contain by keeping things calm, offer support and a response	
The place of differential diagnosis not predominating – this took a back seat. Could have both roles (looking at causes and supporting presenting needs)	7	To prioritise a course of action at a particular point in time (to meet presenting need, not identifying causes, given the level of challenge presented) but which is presenting as a priority (and how best to use limited time)	
Change in EP role over time / through course of involvement	7	Initially, then, remit changed quite a lot	It would have been very different, I think, from initially picking up the case to where we ended up, Hmm So initially the referral was about some behaviour difficulties, some language needs, attention needs, and kind of unpicking, you know, what, how we support this, and then, obviously, as time went on, dynamics at home, possibly were responsible, or lots of dynamics responsible, his behaviour escalated and, I think, and it was then about, how do we keep him safe, how do we understand what he's trying to communicate to us, I suppose. [pause] Yeah I think it was a, yeah, the remit changed quite a lot.

	7	Observations (1) to inform and signpost staff with strategies for interaction (2), to help staff support him to self-regulate (3), to feed into multi-agency meetings (4), staff supervision (TAs) (5)	
Change from hypothesising to containing	7	Changing foci from understanding the communication and emotional needs of child (hypothesising) to containing staff, as child's behaviour escalated (deteriorated)	
Being distracted from hypothesising – original / preferred activity / role	7	Focus of involvement / activity shifted over time as the situation progressed and information came to light	
Is it possible to hypothesise whilst having a supportive / containing function	7	Withdrawing from staff as post ended allowed a renewed focus on hypothesising	
Can you maintain perspective if you are in and amongst?	7	Birds eye view ? suggests not intertwined (allows hypothesising) or being 'in and amongst staff' (containing) – the latter valued by staff versus perhaps what her initial (preferred ?) role was	
EP versus non EPs contradictions in expectations ?????resisting?????		<p>EPs wanting to work at a pace that's appropriate for due process versus non – psychologists wanting a result</p> <p>The time pressure (suggestion of pace) of others' expectations '(all these other people i.e. non psychologists) are waiting (suggesting passivity on their part?) for <u>the</u> (suggestion of linear / singular cause) <u>answer</u> / outcome / result (i.e. 'name for it')</p> <p>EPs wanting to engage in a process (of wondering and being curious) and sitting with a problem i.e. her comfort zone of practice versus what others want</p>	<p>Er and, possibly, other people's expectations in the frameworks, maybe, might have, they're kind, other people's ideas are there, aren't they? Yeah Are you looking to prove or disprove <i>that</i>, Hmm</p> <p>or does that stop you from <i>just</i> wondering and being curious when you've got all these people waiting for the answer, Hmm</p> <p>I suppose, that you're trying, maybe, <i>resist</i> a bit and just, er, be a little bit more open to exploring.</p>
Role expectations / pressures on her activity (choices / decision making)	7	To diagnose with a clear answer as to what is and why a child behaves that way Expectations as to the kind of activities she should be undertaking to fulfil other peoples' expectations of her role	
Customers and EP role	7	Checking out with staff that they were getting what they wanted. Checking match between what was offered and what was wanted. Building an alliance with staff for their emotional support. Being 'present' for staff – the idea of customer: staff needs (emotional support) versus other customer needs (assessment information for multi- agency agendas / meetings)	..." roll up my sleeves and get stuck in a bit with them...maybe a little bit to be in it with them, to show that kind of support..."
EP values / principles	7	Determining what is in the child's best interests in terms of focusing her practice: in this context, what can she do that is of best value / least detriment to him? Duty to the child (1) – child specific factors in the context of the others involved (contextual factors) determines legitimate sites of intervention / activity	



EP values / identity Autonomy in professional decision making	7	Bending rules, stepping outside of protocols and established ways of doing things, judgement calls, permission giving, flexibility in order to: 1) sit with emotions, hold feelings, listen and think and thereby 2) avoiding forced reactivity, aimless work / activity and other's pressurising expectations	
EP decision making	7	Decisive / taking action based on interpretation of information gathered / shared Wanting to be fair on a young child who is already distressed to go through a diagnostic process of further potential strange / distressing activities What takes precedence – being seen to have done everything or the child's welfare?	
EP priority	7	Child's safety	
Accountability, defending a position. Decision making / position taking in a context of pressure and accountability	7	EP being clear of her view, when it is a solitary voice in a context of scrutiny / recording that is meticulous – pressure of being heard, safe in your decision making versus how other professionals practice	
EP theory	7	Existing theories were of abuse / child protection, ASD, copying sibling (i.e. learned behaviour), attachment, language (including EAL), cultural expectations	
EP theory / activity	7	The role of contextual information in interpretation and hypothesis generation	
Difficulties in overlapping phenomenology  Co construction of her theory / hypothesising	7	Responses to one thing / an intervention do not necessarily prove things one way or another (ruling things in / out)  If he had done well in a nurturing provision - might give more proof aligning with an attachment hypothesis. If he had not responded, would it have aligned more with child protection or ASD hypotheses? Neither the outcome of responding or not responding are conclusive – just adds to information available	
Could be either ASD or attachment (overlap)	7	Understanding and use of language could be present in ASD and attachment: either because of a lack of language rich environment or because the child has SCI deficits that would be apparent irrespective of care received.	
Contextual factors (parents skills)	7	Parents lack warmth – the difference between making 'judgements' from 'interpretation' in problem analysis / hypothesising	
language	7	Judgements versus interpretation – what's the difference? Judgement – (bad, suggests power relations / hierarchy) Interpretation – (sounds more neutral and less emotionally connotative) – problem analysis to seek meaning, rather than to disparage.	
Contextual factors	7	Mother's versus father's presentation and their interactional dynamics (also 'information' that gets included in the problem analysis / hypothesis generation) Mum presenting as passive / speaking very little in contrast to dad who was educated, controlling, agenda-ed and centre of things	

Problem analysis - context	7	Role of contextual factors in hypothesis generation / problem analysis	
Assessment	8	<p>Parental recollections of typical early development followed by a change at a point in time</p> <p>A constellation of observable features in the absence of other explanations i.e. no obvious trauma, no major illnesses, no terrible event</p> <p>Balancing out the strength of information from a good period of structured intervention which has not resolved difficulties</p>	<p>Behaviours / responses noticed during a home visit would include:</p> <p>The child's curiosity / exploration</p> <p>The child's anxiety</p> <p>Who the child seeks permission (to play/explore) or comfort from</p> <p>Does child seem to expect a response from parent</p> <p>How reassuring / responsive are parents (do they break off talk to help): are they warm, nurturing and encouraging</p>
EP activity Generate hypotheses Develop a picture	8	Hypothesis generation and alternative explanations – what else could be going on? Via a consideration of factors – a picture of a child's life so far	
	8	Identify areas that people want to focus on Seeking / unravelling what it is people want from EP involvement, working to agree what 'we' are actually talking about, going at the parents' pace, developing a shared understanding, being gentle in approach	
	8	Structured interventions over time	
	8	Bide your time	
	8	Embarks in information seeking by seeing child at home, talking to parents using open questions about the child's experiences (and gaps where things are not known if with foster carers)	
	8	Multiple purposes for a first visit: for child's comfort (no pressure to interact, give child chance to see/ observe her) (1) to reassure parents/ parents comfort, perhaps by addressing myths about psychologists (2) to get background information (3) find about what the child likes (4) find out what toys they have available (5). Main focus for a first visit is expressed as child and parent comfort.	
	8	More of a 'noticing' approach than a formal observation / mental checklist to 'cross off' 'attachment' and 'opportunity' that might account for presentation	
	8	Use of formal checklists is a judgement call (which can help explore in/consistencies) depending on circumstances of referral, for example it offers a form of language (data) that helps others makes decisions about funding	
Who is making the	8	An Initial Meeting (to share concerns, strengths and interests) could be done instead in a	

referral and why could inform some of what is done		setting (as opposed to at home), followed by observation in setting, then a home visit if referral made by setting (rather than Paeds)	
	8	Some significant reference to a subconscious level of assessment or judgement making during an initial visit: of their environment, of relationships / interactions and their opportunities for interaction, language and fun	
EPs own processes are more sophisticated than she imagines or articulates (without the benefit of this process?)	8	Unravelling the nature and purpose of a home visit and the quality of information that is 'extractable' from such an activity (from a psychologist's view) – information that was not within her awareness	
Reflection in action	8	Re-appraisal of the notion of gut feeling	
Evidence based practice or practice based evidence	8	Talks of doubts within her own process and the place of 'hunch' or conjecturing	"I don't know, that's where I wouldn't know, but I'm just kind of <i>conjecturing</i> "
	8	Does 'gut feeling' exist? Is what she describes as 'gut feeling' really gut feeling or is it grounded in practice based evidence that she hasn't had time / space to process (PBE?) and what is the value of PBE versus EBP?	But you you erm talked about <i>gut feeling</i> , and you've mentioned gut feeling tonight <b>Uh huh</b> so I'm just wondering if we can say a bit about where, because you've had a lot of qualifiers, you've mentioned the phrase 'gut feeling', and then said things like, "I don't know <i>if this is right</i> " <b>Yeah</b> which, [pause] I suppose I'm <i>wondering about the significance of gut feeling</i> and the role that it plays and should it be <i>down played or undervalued</i> or [pause] because it's, you've you've made <i>qualifiers</i> as if to say, " <i>This is not research based</i> ", as if somehow if it <i>were</i> , it would be <i>more important</i> ? <b>Or, just, I think, for some, what I could say is, gut feeling is, for some of the parallels that I've drawn, I could <i>bring out and replay</i>, "Oh, when we played this", or, "When we were doing that" Hmm so some of them, obviously, because I haven't <i>been</i> having conversations, or I <i>don't have</i>, I haven't any <i>direct</i>, that's what I'm meaning, was that when I was doing those Right comparisons, I just kind of [pause] could picture the, I've got <i>much more</i> experience of children who I think might have autism or Hmm have got a diagnosis <i>as a group</i> of, say, <i>literally hundreds more</i> than, it's <i>very rare</i> anybody comes out and goes, "Ooh! They've got attachment difficulties", and, again, it's, I suppose the boundaries for me is, are we looking at</b>

			attachment difficulties <i>as in the normal population</i> Hmm with insecure attachments and what have you, or kind of more <i>significant</i> attachment difficulties, as in whatever type, D disorganised...So, although we might use the phrase 'gut feel', <i>if given the time</i> , you probably could <i>rework it, rethink it</i> and <i>then draw on</i> the nuggets of evidence that were there, which is what <i>informed</i> your gut Yeah what you've come to describe as gut feel? Yeah, I would think so.
	8		<p>"thought that was interesting, that's over the case of, since about November, was when he went into foster care, and it's now only February, isn't it. So, <i>emotional</i> change appears to be quite rapid, we're not completely out of the woods here</p> <p>Hmm But So, with that boy in mind, I don't know his <i>brother</i> that well, but I've had one or two children <i>in the same class</i> [unable to hear 19:08] I'm thinking of six, seven year olds, <i>what's the difference</i>, why when what you see is a child effectively as far as school are concerned kicking off, not engaging, not following the Yeah routines. So that was <i>part</i> of the thing which was, just trying to think of the <i>snatches</i> that I got. So <i>play</i> was one of the things. Is this on this particular child Erm or your broader thinking? A bit of both, but obviously it was him Hmm that made me start to think, and think, and then I've kind of, I suppose, checked it out in my head against a kind of couple of kids, so that in the <i>same school</i>, effectively in the same <i>year group</i>, and I've assessed them both within the last year using [laughs] probably, as part of it, because numbers counted British Ability Scales as well, so they've kind of, we've done other things, but I've kind of done a fairly <i>uniform</i> set of things with them as well, and it's like, <i>how do they strike me as different</i>. Is that?</p>
EP theory	8	A previous approach to problem analysis (is it ASD or attachment?) which includes 'hunches / best guesses' and 'talking things through' rather than having a framework	
Overlapping phenomenology	8	Balancing out the strength of information from a good period of structured intervention which has not resolved difficulties	
	8	Hypothesising / unravelling as to causes of observable behaviour in the realm of social	

		communication and interaction: is SCI presentation due to an understanding of / interest in reciprocity or has a child (who had predisposition to be interested) given up being communicative / interactive based on experience of others lack of reciprocity – attempts are futile	
	8	The impression from a home visit allows some consideration of how both 1) opportunities that are available and 2) attachment might contribute to a presentation	
Comorbid attachment / ASD	8	The potential for attunement with almost all children with autism (re prerequisites for social connection) can be a threat to the development of attachment	
See separate doc detailing her overlapping phenomonology	8	Expectations of change (speed of change and nature of change) when care circumstances change.  Play, overload, memory, waiting, routines, stealing, “I”, social interaction, lying, vocabulary, mime are all areas she has reflected on since the first discussion	
EP values/ principles/ethics  Parent and child comfort with meeting / working with an EP	8	Main focus for a first visit to ‘see a child at home’ is for parent and child comfort (allow them to meet a stranger and address misconceptions / potential anxieties about a psychologist’s ‘assessment’)	
Reflection in action	8	At closure of first interview reflects on a potential comparison / imbalance between ‘permission’ to assess / diagnose autism and attachment and asks the question, ‘what stops people looking at attachment?’ and, ‘Is that right?’	

## Appendix O

Q4. How do EPs conceptualise the distinctiveness of their contribution to problem analysis in this particular area? Thematic extracts from individual volunteers combined to enable cross case analysis.

Black – interview 1 Red – interview 2. Green - Interview 3

Dimension	Vol	Talk	Quotes
EP identity versus other professionals	1	<i>As an EP you can see other behaviours that might tick other boxes</i>	
EP identity versus other professionals	1	EPs have knowledge that perhaps other professionals don't have	<i>I think, as a practicing EP, you've got in your head certain things that are, I don't want to use the word <b>red flag</b>, but are things that you [pause] find your ears <b>prick up at a little bit more</b> than they would do for maybe something else Right or for <b>somebody</b> else</i>
EP identity versus other professionals	1	Talks of problem analysis / hypothesis generation as a mental journey not a pathway (perhaps like CAMHS algorithm). Note to self – EP activity as a fluid creative process of hypothesis generation depending in circumstances versus the checklist type approach of CAMHS pathway / algorithm and when people lack 'real (enquiring and interpretive) skills' (as described) or lack depth of understanding (see local comment re "we really struggle in CAMHS because we don't know about child development" they are reliant on pathways and checklists (and tools) to guide activity	
EP identity versus other professionals	1	Schools speaking authoritatively (it's definitively this, it's definitely that). Parents banging on until they get the label. Medics perhaps not interpreting the whole thing in a concise and truly evaluative manner	
EP identity versus other professionals	1	Schools claim expert status, based on limited training, and make bold conclusions based on very little analysis whereas EPs observe, unpick, cross reference / triangulate to offer alternative hypotheses / interventions / ways of working	
EP identity versus other professionals	1	People, including EPs and others, operating and remaining within their job role and limits of their training. EP identity as not qualified to diagnosed but to contribute information to a diagnostic process YET some school staff giving diagnostic opinion to parents (and how this sets parents up against EPs who begin involvement when this has already taken place)	
EP identity versus other professionals	1	EPs – think psychologically, about a whole child, that perhaps others don't focus on	

EP identity versus other professionals	1	CAMHS clinicians don't have the knowledge and skills or understanding to undertake assessments in schools / educational settings. EPs as uniquely placed / skilled to get education based information (and interpret it / make meaning from it – psychologically)	
EP identity versus other professionals	1	Local politics not helpful in keeping child's interests at fore. NHS and Education both refusing to fund the contribution of EPs to the multi -agency process recommended by NICE, so CAMHS seeking input via the 'backdoor'. Now CAMHS clinicians (who have no training in educational theory or practices) and teachers (who have no psychological training) are making up the 'educational' component locally or substituting for the contributions once made by EPs	
EP identity versus other professionals	1	OMG, Wow, that is so bad, honest to god, madness, utter madness, god, unbelievable – strength of feeling conveyed at the 'replacement' EP cover for diagnostic contribution	<p>Shall I shock you? <b>Go on then.</b> At the same said meeting, the lady that's in the charge of the [cough] process in another local authority, very close to us, admitted that they were struggling in CAMHS with the under-fives because they didn't have any training in child development, but she's been allowed to go on a course. <b>Oh, my God!</b> So the lady who coordinates the neuro-developmental difference process hasn't got, actually, any understanding of what neuro-developmental typical might look like. <b>Wow!</b> [pause] <b>That is so bad, isn't it?</b> Well, how come there wasn't just this ginormous crack appear in the floor and her chair fall into it [laughs]. <b>Honest to God.</b> <b>And does that go back to the NICE guidelines that said there should be a clinical or an educational psychological view?</b> Well, it says <i>and or</i>, but the way they're getting away with it, psychologists don't actually see the children, but they <i>attend</i> the discussions, which is why they <i>wheel out</i> nurse practitioners and primary mental health workers to do the dirty work that even though they're not qualified for it, and then they'll get a psychologist to <i>sit in</i> on the discussion. <b>Wow!</b> And in the meantime, the people gathering the information, have had to go on a child development course. <b>And yet you've got a bunch of people who could...</b> Sat ready to go....<b>actually do it.</b> Can do the job, across age groups, across learning disability range. <b>Oh wow!</b> And are trained in it, actually [laughs] <b>That is madness, utter madness.</b></p> <p>But what was even more mad is that <i>nobody</i>, apart from [name of colleague] and I, sat there with mouths on the table [laughs]. Well, [name of another EP], maybe did. Anyway. <b>God! Unbelievable.</b></p>
EP identity versus other professionals	1	EPs (subtly different to teachers) in that we are 1) taught to think of alternative hypotheses by looking for evidence for or against and 2) EPS come back to that ecological model (i.e. have a theoretical basis behind knowledge acquisition	Erm and you mentioned getting reactions from <i>staff</i> when you've tried to suggest alternatives, "Hang on a minute, let's think about..." <b>Hmm</b> and I just wondered if we could say a bit more about the ways in which you understand the skills skill sets of teachers and EPs differently? [pause]

		and application). The judicious application of knowledge rather than indiscriminately applied knowledge	<p>Because it felt like you were <i>frustrated</i> with the <i>training</i> that they had and what they <i>then did with it compared</i> to what an EP does, and I wondered if there was some more to be said [pause] about the skill set of <i>teachers</i> and what they do with it. Hmm, mmm. [pause] I think [pause] the <i>subtle difference</i> [pause] for me, between being a teacher and an <i>EP</i> is as <i>EPs</i> we were <i>taught</i> to think of alternative hypotheses [pause] and to <i>look for the evidence for or against</i>. [pause] I always remember one <i>key lecture</i> at uni where [name of tutor] said, “Somebody walks through the supermarket door, you hold the door open for them, they don’t say thank you. Why didn’t they say thank you?” and it was, okay, why else? Something else? <i>Why</i> else? <i>Why</i> else? And, <i>for me</i>, that has <i>driven a lot</i> of my own EP practice, whereas a <i>teacher</i>, I remember going on a course on ADHD, and suddenly all my kids in my class were ADHD.</p> <p>Oh, right. Do you know what I mean? Er you get that <i>small</i> amount of knowledge, and you <i>conceptualise</i> that very, very quickly, and you <i>suddenly</i> become an expert in it because you’ve had a little bit of training on it. Whereas, as <i>EPs</i>, again, we come back to that ecological model, what <i>else</i> is going on? Is it about the knowledge plus the thought process and analytical skills, then? Yeah, <i>probably</i>. Because, is what you’re saying about the teacher is that they <i>get the knowledge</i>... They <i>get the knowledge</i>. ...but not how to use it? <i>Not how to</i>, yeah, yeah. And I think, again, having been a teacher and an EP, it’s that <i>subtle shift</i> in that <i>application</i> [elongation] What does it actually <i>mean</i>? What am I going to <i>do</i> that is different? Whereas, the teacher, you get your training on ASD, suddenly all the kids are ASD. Hmm But we come from it from a different angle. Also think about <i>what</i> are we going to do to make things different.</p>
EP identity skill set	1	Interpret the whole thing, being concise and truly evaluative, looking at the broad issues Interpret / appraisal of information / evidence versus just gathering information. The whole thing – what is sufficient? ? ref to school contexts, differences across contexts – that others can’t do?)	
EP identity skill set	1	Able to comprehensively cross reference, triangulate, use other skilled peers for reflective practitioner supervision, co working	
EP identity skill set	1	EPs – think psychologically, about a whole child, that perhaps others don’t focus on	
EP identity skill set	1	Now CAMHS clinicians (who have no training in educational theory or practices i.e. are not education specialists) and teachers (who have no psychological training) are making up the ‘educational’ component locally or substituting for the contributions once made by EPs – arguable that neither teachers and the CAMHS clinicians are less well placed (note to self about training in child development) – evidence by the fact that locally they asked the specialist ASD	



		EP (who had just been disposed of to train CAMHS staff to do classroom observations)	
<b>EP identity</b> Change in practice over time		Change in <u>practice</u> over time and the difference between ASD <u>knowledge development</u> and attachment knowledge development. These days, more focused on what to look for and use of more specific tools and the benefits of having worked with a specialist senior EP – specialist guidance from a specialist colleague (ASD) whereas for attachment, no specialist guidance from a more skilled colleague or access / signposting to specialist tools	
		Knowledge extension through engagement with literature	
		<u>Feelings</u> - More confident now in ability to look for information, connect pieces of information together to generate hypotheses	
<b>EP identity</b> Practice development	1	Recommends EPs shadowing / observing each other (co-working)	
<b>EP role – role boundaries</b>	1	People, including EPs and others, operating and remaining within their job role and limits of their training. EP identity as not qualified to diagnosed but to contribute information to a diagnostic process YET some school staff giving diagnostic opinion to parents (and how this sets parents up against EPs who begin involvement when this has already taken place)	
<b>EP ethics – quality of practice</b>	1	Anger and irritation at a lack of analysis of factors leading to an interpretation	
<b>EP ethics – role boundaries</b>	1	Professionals confining comments to their areas of training / qualification (TAs mentioning ASD to parents)	
<b>EP ethics – role boundaries</b>	1	CAMHS clinicians ‘assessing’ in school settings without qualifications / knowledge / understanding	

EP ethics -role boundaries	1	Feels sad that the psychological information from an educational perspective in the diagnostic system is being eroded (dumbed down?) by nurse practitioners doing classroom observations	I've got here about too many going through diagnostic processes, and I wondered if you were comparing now with <i>now</i> , whatever <i>now</i> is with <i>before</i> , whenever <i>before</i> was, so I've put since when and is there again diagnoses coming through left , right and centre? Erm Is there again here a sense that some sort of core value principal is being <i>eroded</i> or expected professional practice that's being affronted? Like an artist looking at something ugly [both laugh] is kind of what I, some sort of <i>grotesqueness</i> going on [pause] that, you know, almost a mess that you couldn't bear to look at. I find it really sad, in a system [pause] that worked well, that involved [pause] the EPS providing educational perspective is being eroded. Because you went on to say that people with <i>no background in schools whatsoever</i> . Yeah. And <i>today</i> , whilst I was at <i>panel</i> , we saw some paperwork that has come from CAMHS where next to, it's like a table, and they've got clinician information and what it is they wanted, and parent, speech and language, cognitive, next EP, no EP information received. And I just thought, "Is that <i>all</i> they <i>value</i> , the EPS for, doing a cognitive assessment for a child with possible ASD?" whereas <i>before</i> we were looking at how does the child <i>respond</i> in a classroom, <i>how</i> can we <i>mediate</i> their learning. So you can't de-contextualise assessment? <i>Oh, God, yeah</i> . [pause] And, you know, a <i>nurse practitioner</i> , don't get me wrong, <i>nowt</i> wrong with a nurse practitioner, but she is <i>as skilled</i> in classroom observation as <i>I am</i> in taking out sutures. [Laughs] Yeah, I sometimes think I should just get a Woods Light and build a tower of four bricks <i>Yeah yeah</i> and weigh and measure them. <i>Yeah! And that's the system that we're with now</i> . [pause] And it was politics. [pause] But at the end, you've got some young kids there who [pause] may or may not get the right help because of a political decision over who pays for [pause] an EP assessment.
EP role – boundaries (shifting re funding rather than skills set)	1	EPs as rescuers (of a broken diagnostic system) if we produce reports or as appropriately professional response / activity in the best interest of the child	
Ethics versus politics	1	The political decision not to fund EPs contribution to the diagnostic process means that a quality of contribution is lost to the detriment of sound outcomes for children	
Practice over time – both her understanding and her practice approach	2	Agrees knowledge has deepened to a different understanding and now relies less on use of tools / techniques and more on observation and discussion	

EP identity versus others -unique positioning and skill set of EPs	2	EPs have skills that allow us to do this (rely less on tests / tools and more on obs / discussion to get a feel for a child) whereas others perhaps cannot do this  Would NICE agree with this approach? CAMHS locally don't seem to like this 'feel' approach – they send questionnaires through the post, do ADOS, do WISC... all very concrete, very structured.	
EP ownership / control over activity	2	Traded services making demands – is the ownership of professional activity being reduced / decreased for EPs in the context of school's as independent private customers (now compared with being wholly employed to act on behalf of the LA)	"[unable to hear 13:11] a focussed observation <i>in the meantime</i> ", so I wondered if you were considering there that there was an opening for assessment <i>over time</i> Yeah rather than it being completed in one sitting Yes in an ideal world. Yes, and I think, you know, thinking about things like the Coventry Grid, you really need assessment over time because you'd have a hypothesis, erm and I think it even says things like, you know, if, er you know, [pause] if it's an attachment issue and, you know, the situation's changed, then you would expect the child to improve, where you wouldn't necessarily expect that, so, I mean, that kind of implies that you're being around over a period of time. Yeah. [long pause] Erm [pause] But you've already mentioned although that, I suppose, time is one of the things, you're not always at liberty to <i>choose and direct that</i> , are you? No, no, very rarely. Well, these days. Yeah Far less than you could before.
Not to diagnose EP activity informed by good practice guidance	2	She wouldn't diagnose autism – as NICE guidance recommends this should be a multi-agency assessment for ASD	
CAMHS role / identity	2	Feels it is the accepted position that CAMHS are the only service that might be qualified to give a label of attachment disorder (psychiatrist or clinical psychologist or some sort of senior practitioner) based on copious history informing real evidence	
EP identity as LA rep Skill set	3	LA representative – employee – role is to find out what is going on (suggesting not confined to asd and / or attachment – are you limited to this activity is you are employed on the / by a diagnostic pathway	
Skill set and experience  Professional role boundaries – speaking within your realm of qualification	3	Reference to school staff talking beyond their skill set / training versus CAMHS (and her too? Perhaps by implication since she agreed with CAMHS)  A perceived lack of professionalism in school staff's interaction with CAMHS – speaking beyond their expertise  And by implication questioning her relationship with the school, and their views	well, I have, I can picture myself (unable to hear 16:56) <i>feeling</i> myself getting more and more annoyed about things and having to be very <i>careful</i> to say, to not say too much or, you know, use words carefully, <i>because</i> it's not <i>sat easy</i> . Those meetings have been difficult. [pause] And the difficulty, I think, is a <i>conflict</i> of emotion, maybe, for me, because there's conflicts of, my job is to support school in, because they have this child every day and they're working hard to meet this child's needs. Which they were, are, but at the same time feeling

Not a shared professional etiquette / courtesy		about her	compromised and not wanting to feel <i>collusive</i> in terms of berating CAMHS and when, patently they didn't have [laughs] the expertise to do that. The school didn't have the expertise to do that? The school didn't have the expertise to do it. And to be, you know, I guess, [pause] maybe underlying that is that sense that they could question <i>me</i> . If they feel that they can question someone from CAMHS and say, "You're not doing your job properly, you know, why aren't doing this, you should be doing that". So maybe there is an element of that as well, thinking, "Maybe I don't have the same relationship with the school as I thought I had", because they've questioned so strongly and, <i>for me</i> , the big thing, I think I mentioned last time, was that lack of respect. When you're talking to a <i>fellow</i> professional, you can't tell them that they're wrong. You can ask questions and not say (unable to hear 18:36) but to basically <i>force</i> them into something when they've said from their professional opinion, "This does not feel like it should be this", felt, I didn't like that.
EP identity – added value (how and why we think, not just what we think)	3	EPs have a responsibility to share their professional opinion which is grounded in theory –so someone else might have come up with the same conclusions but the difference with an EP is that they can explain why they came to a particular conclusion / opinion. They can rigorously justify the thought process used to arrive at an interpretation	
Change in practice over time – greater acceptance of own / others skill set when talking within areas of their own competency / proficiency	3	Professionals making comments within their remit / within their own domain of expertise - confining comment's / challenges to areas in which they have had training	
Confidence and articulation of hypothesis generation	3	<b>Confidence increased over time in the activity of hypothesis generation and articulation</b>	
Change in practice Identity - Change in EP skills over time	3	Better acceptance of other's contributions / skill s set / proficiency - a more developed perspective of their roles / practices within a domain of their own expertise	
Within the umbrella of LA role	3	Daunting when executing role on behalf of LA – to find out what is going on – this has to be right, sense of responsibility , its down to you	
Respect, appropriate role boundaries	3	School staff reading out a letter from a swimming teacher who claims it must be autism	

EP ethics / responsibility to voice professional opinion which is grounded in theory	3	<p>EPs are responsible for saying what they think</p> <p>Why we get paid what we do – value for money, why we are different to others</p>	<p>Is there anything else, [name] that you would think is important that we capture? <b>Anything else?</b> [long pause] Yeah, maybe one thing about talking to EPs, and that is, we <i>have</i> to listen to others and, obviously, respect what they say, that's important and I feel very strongly about collaborative work and partnership working, but at the <i>end of the day as well</i> [pause] we we sometimes have to put ourselves on the line and we have a professional responsibility to say what we think, and that's actually a lot of what we get paid for. Hmm And therefore [pause] not to shy away from that, [pause] because it would be very easy just to describe what's going on, [pause] lots of people describe what's going on and they come up with a few strategies, but it's that <i>middle bit</i> of saying, "So what you see, what's going on", and you need, and I think that's where I've got to, I'm saying about that <i>confidence bit</i>, <i>it is around</i>, you know, the world isn't going to go under your feet [laughs] if you say something and someone disagrees with you, but on the whole, most of the time, probably not, people won't disagree with you anyway. Er you <i>do</i> have to take that professional responsibility, and I think that's important, because for me that's, because there are times when I think, "Well, that person could have come up with that, but I'm getting paid twice as much as them". The reason being is that, actually, we can say <i>why</i> we've suggested that, Hmm base it in theory, but also we'll be the one in the meeting who said, "We think that..." . I don't know whether you've come across that 'Oh well I wouldn't like to say', you know, and everyone looks to you as the EP because they want <i>you</i> to say it, and that's one of the responsibilities that we have, I think, Yeah [pause] which, so you've got to put yourself out there sometimes [laughs] to say what you believe, and as long as you've done all your reflecting, and thinking, your referring back, you know, <b>and you can justify...</b>And so we've kind of come full circle <i>back</i> to the identity of an EP, <b>Yeah</b></p>
<p>EP Skills / identity</p> <p>Facilitator - skills mixing with role</p> <p>How this interfaces with working at speed</p>	5	<p>Expertise to execute role of facilitator</p> <p>A skilful facilitator</p> <p>Conducting a procedure with expertise creates an environment conducive of comfort</p> <p>Listening out for terminology and how YP are described</p> <p>Working at speed does not sit well with psychologists practice where time and space for thought are essential</p> <p>Trying to engage in a piece of solid psychological work in a context which does not lend itself to colleagues 'being freed up, closing the door, turning off</p>	

EBP or PBE?		phones, not to be interrupted'. Feels bulk of her work is intuitive (not reading, theoretical or research based) – has her work become so automatic, she now sees what was once theory, as intuition. Sees herself as some distance from theory	
EP theory drawn on in the course of activity	5	Attachment, Consultation, Resilience, Narrative The role of others / stakeholders Family Systems / transactional / script analysis / psychodynamic	Would other practitioners (camhs PMHW, teachers be drawing on this in their 'evaluation' / interpretation?)
EP identity	7	" for me, as a psychologist"	
EP versus non EPs contradictions in expectations ??????resisting?????		EPs wanting to work at a pace that's appropriate for due process versus non – psychologists wanting a result  The time pressure (suggestion of pace) of others' expectations '(all these other people i.e. non psychologists) are waiting (suggesting passivity on their part?) for <u>the</u> (suggestion of linear / singular cause) <u>answer</u> / outcome / result (i.e. 'name for it')  EPs wanting to engage in a process (of wondering and being curious) and sitting with a problem i.e. her comfort zone of practice versus what others want	
Role expectations / pressures on her activity (choices / decision making)	7	To diagnose with a clear answer as to what is and why a child behaves that way	
	7	Expectations as to the kind of activities she should be undertaking to fulfil other peoples' expectations of her role	
Tensions / conflicts / role expectations/ EP identity	7	Others views that she would diagnose / give a label – she does not see herself as a psychologist in this way / not her role	
EP role / identity as distinct from others	7	Sitting with mess and complexity	
EP values / identity Autonomy in	7	Bending rules, stepping outside of protocols and established ways of doing things, judgement calls, permission giving, flexibility in order to: 1) sit with	

professional decision making		emotions, hold feelings, listen and think and thereby 2) avoiding forced reactivity, aimless work / activity and other's pressurising expectations	
EP decision making	7	Decisive / taking action based on interpretation of information gathered / shared	Is this possible if you are working in a pathway of a series of expected steps, like a camhs clinician working within an algorithm (a WISC is always needed for an ADHD pathway for example)
Accountability, defending a position. Decision making / position taking in a context of pressure and accountability	7	EP being clear of her view, when it is a solitary voice in a context of scrutiny / recording that is meticulous – pressure of being heard, safe in your decision making versus how other professionals practice	
EP values/ principles/ethics  Parent and child comfort with meeting / working with an EP	8	Main focus for a first visit to 'see a child at home' is for parent and child comfort (allow them to meet a stranger and address misconceptions / potential anxieties about a psychologist's 'assessment')	Why EPs might not be well placed ?
	8	Trust, de-bugging, de-mything psychologists for families, managing parental guilt	
Limitations of psychologists working with families	8	Capacity (1), shared language (2) and (3) role i.e. outreach worker, not psychologists maybe more likely to develop relationship with family	
How to 'normalise psychologists' with / to families	8	EPs perhaps not as 'accessible' to families for a range of reasons: Title, impressions, associations, stereotypes and misconceptions are barriers and whether trying to normalise psychologists by aligning them with Education can back fire.	"No. No. And, as I say, I don't think psychologists, I wouldn't change the name, but I think you've got to bear in mind that A most people probably couldn't naturally spell it, and if you can't <i>spell it</i> , would you trust it? Er teachers, they can, but again, <i>teacher</i> , I was a teacher, I think that's, oh, that's pretty ordinary for many people, they say, " <i>Dear God</i> , you were a <i>teacher</i> ", and maybe <i>that</i> wasn't their <i>fondest</i> memory, and Yeah immediately said, "Oh, you were a teacher, you were a bossy brr brr brr", and maybe I've <i>stirred up</i> a whole load of <i>other</i> Yeah things, you know, in my attempt to sort of <i>normalise psychology</i> and put it with the education bit. Who knows, who knows? [pause] But I think it is <i>that fear</i> that, I will be able to just sit there and look into their minds [both laugh]. I don't know, I still don't think any of us can quite get away with that, that's what psychologists do, isn't it, somehow? Hmm, maybe.
Others' expectations of EP role	8	The idea that EPs disappoint as we don't do any of what they expect (come up with answers / fix things)	And maybe we're <i>disappointing</i> because we <i>don't do that</i> and kind of we don't [laughs] come up with the, "Ooh, just do that", and the answer, we don't come up with the answers they want.

EP skills / identity	8	Experience of children in Early Years where there are other difficulties, including possible attachment may position her differently to other EPs	
	8	Complexity of her casework, many children have physical medical needs, others have identified delays, and the majority have 'question marks' around social communication and interaction.	
Her identity / position in relation to: research in general, researcher, other EPs (area of activity and ways of thinking), and as an EP versus a Health worker	8	Relationship to researcher – and their careers together, lots of previous discussions around autism and how children present	
	8	She feels our experiences complement each other in terms of age range – she feels secondary is not her area	
	8	Other comparison between us: (not just age range EY vs Secondary) but also our approaches, describing mine as using tight thinking, grids, asking lots of questions compared with her view of herself as woolly and not asking questions	
	8	Reference to number of years as a practising EP (in the field)	
	8	Perceives herself as different to those on the doctorate programme who are connected to theory, whereas she feels she recognises theory when it is made explicit, but her practice is automatic pilot / subconscious	
EP practice as different to other professionals, with a unique skill set and unique positioning to see and interpret normal / typical development i.e. versus CAMHS, including psychiatry, and Paeds	8	Others' approaches of diagnosis by questionnaire, her major worry is diagnostic teams which are ticky boxy, by individuals with limited experience of children and families to be able to fully explore / consider what is going on	
	8	Discussion about the skills set offered by EPs and SALTs vs CAMHS staff to make judgements about norms / expectations – SALTs/ EPs see lots of ordinary	



		children and have a strong sense of what's typical for age, differentiate delayed from impaired, see children in context and are better placed to judge, "is this what we would be expecting". The problem with CAMHS is they have scant knowledge of children/ typical children AND contemporary schooling (don't work in contexts inhabited by children (homes / schools)	
	8	Scant training for 'doctor training register' (a couple of hours in a nursery), and this is basis for medics to build on, on their way to becoming psychiatrists – medics having limited exposure in their training or job roles to see normal, healthy, well (not physically poorly or emotionally upset) typical children  We are uniquely placed to see typical / normal development	<b>We are, we're probably uniquely placed to see typical, brackets normal development. Health visitors would have more of that kind of background, but they're not involved"</b>
	8	As an EP, tends to shy away from attachment because others tend to think of it in terms of disorder	
	8	Feels she doesn't think about attachment as often as she maybe should	
	8	Has had much more experience of 'do you think it might be ASD?' than 'do you think it might be attachment?'	
Changes in diagnostic rates over the course of her career A historical perspective that is afforded by her age (and therefore her parents' ages) and length of service	8	Explores reasons for apparent increase in prevalence in context of changes over the course of her career – in the beginning, EPs only saw 'classic autism' and many children were not in day care or nurseries (anyway, so why would they come to attention of EPs). Then, Aspergers became a diagnostic classification (appeared in manuals) and children increasingly attended settings (1974 Education Act – education for all children, not placing them in hospitals – Educationally Subnormal), and reduction in stigma in contrast to the openness of today probably all contributing to rise in diagnostic rates. Recounts parents' stories of 'crocodiles of children' (who weren't educated) who she was 'pulled away from' and a significant stigma existing	
Unique experiences and place of foster carers over EPs and birth parents	8	Foster carers as a group are in a unique position to talk about children's early development: they've had much more exposure of lots of children, say compared with birth parents who have 'only had their own' and by default have had increased exposure to children who have experienced early disruptions, neglect and disadvantaged early experiences	
Changes in EP practice / understanding over time	8	Different developments in her knowledge base. Done very little in area of attachment post- graduation (1970s), whereas she feels her knowledge of autism has developed alongside her work, perhaps because her original interest	

How practical activity (focus at work) influences knowledge development		was in children's language development. Feels if her work role had required it (had been around fostering / adoption, for example) she might have had more practical questions to address which would have meant her practice in attachment would have evolved, alongside her work practice, in the same way it did for autism	
EPs own processes are more sophisticated than she imagines or articulates (without the benefit of this process?)	8	Unravelling the nature and purpose of a home visit and the quality of information that is 'extractable' from such an activity (from a psychologist's view) – information that was not within her awareness	Why are we so poor at being clear about what we are doing? / our skill set

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## Appendix P

### EXAMPLE EXTRACTS FROM FORMATTED TRANSCRIPTS

volunteer\_2\_interview\_1 [Compatibility Mode] - Word

FILE HOME INSERT DESIGN PAGE LAYOUT REFERENCES MAILINGS REVIEW VIEW DEVELOPER

Read Mode Print Layout Web Layout Outline Draft Ruler Gridlines Navigation Pane Zoom 100% One Page Multiple Pages Page Width New Window Arrange All Split View Side by Side Synchronous Scrolling Reset Window Position Switch Windows Macros

Views Show Zoom Window

2 1 1 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 17 18

### Volunteer 2 Interview 1 20th October 2015

229 Are there specific ways in which you feel *that's* different in autism compared to attachment?

230 *Erm* [sighs] Social interaction? *Erm* Yeah, I tend, I'm not even sure of this one, really, I mean, I

231 tend to think of kids with attachment as *er* [sighs] being, *lacking trust* of other *peo*, their

232 difficulties of interaction often *based* on a lack of trust

233 Right

234 and a need to, *er* in a way, *use* people to get their needs met, *erm* sometimes not necessarily

235 in a *pleasant* way [laughs] okay, so it's kind of *survival* and

236 Yeah

237 *you* know, if I need to [pause] be better, and a need to sort of *be on top of*, if you like, or, you

238 know, whereas I don't think those kind of, *erm* that that's not the case for young people with

239 autism *erm* who tend to, who may *lack*, *just lack the skills of knowing* how to communicate. I

240 mean, for example, I can remember an autistic boy who kind of *stood* among a group of

241 children without *any skills* in knowing

242 Yeah

243 *how* to talk to them, *er* but sometimes a desire to be part of that group. Yeah so I think there

244 are *subtle*, they both struggle with the *skills needed*, but there are *differences* in the way they

245 typically present, complicated by the fact that, you know, no two children are the same anyway

246 [laughs].

247 Yeah

248 *and* kids with autism [laughs] can be *hugely* different, as can kids with attachment difficulties.

249 ER [Sighs] [pause] I mean, there's a difference in their attitude, for example, *sharing* and, you

250 know, children with attachment, it's very much *erm* linked to their *emotions* and sort of *need* to

251 possess things, *erm* whereas I don't think kids with autism necessarily have *that* feeling, but

252 they don't like somebody to *invade* their space and they like to just, they don't want anybody

253 to get in the way of their doing their own [laughs] kind of thing.

254 So is it, are you talking about maybe observing this, what looks like the same behaviour but having

255 different underlying reasons?

256 Yes, sometimes, and you need to see, or not necessarily see quite a lot of different

257 behaviours, because I think we often don't have the luxury of that, but you can check it

258 against people that know them well and how they see them. I think, and, you know, a key area

259 where attachment is different is the level of emotional *investment* in what's, [pause] in what's

260 happening around them and how their emotions can very *easily* be triggered, and yet you see

261 that in autism as well, but that's often, well, you see that in autism too [laughs] don't you.

### Volunteer 2 Interview 1 20th October 2015

262 So [pause] is this another one where

263 Hmm

264 *it's* the same scene, but it, that might look the same, but the reason behind it is different?

265 Hmm.

266 So, if someone with an attachment [pause] difficulty has an *emotional* investment, how would you

267 describe the nature of their emotional investment?

268 Ah [sighs] Ah that they, I can't think, they can be, their emotions can be triggered by things

269 that perhaps relate to experiences they've had, and that can be quite *unpredictable*. I suppose

270 it's about, if you've got your hypothesis of, is it attachment or is it autism, if you *respond*, *erm*,

271 you can *test out* the hypothesis, I mean, if a child is becoming angry and upset and the

272 hypothesis is that they're autistic and people are invading their space, if you *remove them* do

273 they then calm down? *Erm* in that same situation it's unlikely that, I think, a child with

274 attachment would necessarily *just calm down*, so you would be testing those kind of *erm*,

275 [pause] hypotheses, although it's not as straightforward as that, is it [laughs].

276 Well, are you talking about testing *erm* hypotheses in *naturally occurring* circumstances? So

277 Yes.

278 So hypothesis is in your head,

279 Yeah *Yeah*.

280 *and* you ask a staff member to reflect on,

281 Yes

282 *how* would you imagine

283 Yeah

284 *rather* than

285 Hmm

286 *set up* an experiment? [laughs]

287 Well no, you couldn't do that, that wouldn't be [laughs] *Er* no, you wouldn't do that. [pause]

288 But it might be that you've had a consultation where you've made some *suggestions*

289 Right

290 *and* the success of those would *er* make it perhaps clearer what the underlying difficulties

Microsoft Word interface showing a document titled "volunteer\_2 Interview 2 12th November 2015". The ribbon includes FILE, HOME, INSERT, DESIGN, PAGE LAYOUT, REFERENCES, MAILINGS, REVIEW, VIEW, and DEVELOPER. The font is Arial, size 10. The document content is split into two columns, 11 and 12, showing interview transcripts. The text in column 11 includes lines 288 to 316, and the text in column 12 includes lines 317 to 346. The status bar at the bottom indicates PAGE 5 OF 36, 10064 WORDS, and the date 04/01/2017.

volunteer\_2 Interview 2 12th November 2015

288 [Laughs].

289 Well, yes, [laughs] yeah.

290 You know, it is, I mean, I do feel the end justifies the means, but it's dodgy ground at times.

291 Yeah

292 but otherwise, why bother doing an observation.

293 [Pause] Meaty stuff, isn't it?

294 Mmm.

295 Eem. Oh, well, you've gone on to talk about consent there.

296 Hmm

297 you know, if a parent says no. Eem you've been very careful with your wording around blame

298 Mmm

299 and, fault, and I said there, with regard to being careful with wording, if you believe that there are genetic components

300

301 Mmm

302 or predispositions and environmental triggers, for both autism and attachment, are there ways in which you handle the wording differently with autism over attachment, i.e., do you consider them both to have an element of potential blame, and is that element of blame equal? You talked about the problem with attachment, blaming parents, but...

303

304

305

306 Yeah, but, no, I don't think the blame, I don't think it's equal blame, I think attachment is much, by definition, it's more clearly linked to environmental factors, you're not born with, you can't be born with an attachment disorder. And all this thing about predisposition, no, I think there's a huge difference, there must be a huge difference. [pause] I guess, yeah, it would be, you'd be drawing circles, wouldn't you, environment plus a bit of genetics, little one, equals attachment

307

308

309

310

311

312 Oh right

313 maybe, and then, you know, a little environment plus big genetics equals autism.

314 So the circles would look the different sizes?

315 Yes, I think they would, yeah.

316 Like that?

11

Volunteer 2 Interview 2 12th November 2015

317 Yeah.

318 Environment, genes, mmm. And in there, that's where the blame would be?

319 Mmm. If you want to call it blame, I mean, it's not always, but I'm not blam... I mean, if somebody's got a mental health problem, it's not their, I wouldn't want to call it blame.

320

321 Yeah

322 it's an environmental factor. But, nevertheless, if you were that person with the mental health problem, and your child had the detachment disorder, you may well, I might trigger a huge feeling of guilt.

323

324

325 Right

326 you know, and that's what I don't want to do. And I wouldn't give a, if I thought someone was autistic, I wouldn't give the parent a lecture on the possible environmental factors that might have contributed to that, because, actually it's not necessary. And don't ask me what those are because, I mean, you know, are they, is it living near a road with toxic chemicals or eating too much God's knows what when you're pregnant, I don't know that

327

328

329

330

331 Hmm

332 but, you know, I know there are suspected triggers, aren't there.

333 Yeah

334 But I wouldn't bring that into a conversation.

335 Did you say eem [pause] previously what your view was on those suspected triggers, did you, or that you're aware of these other triggers, the genes plus the bit, in your understanding of what's out there in terms of different theories, did you have a particular...?

336

337

338 Are we talking about autism or attachment or both?

339 Autism, just like you said you had a particular...

340 No, no, no, I just think, it's just that whole question of why we're seeing so much more autism. Is it because of the way, I mean, I suspect, and I suspect it's a little bit like why we've got so much asthma,

341

342

343 Yeah

344 there's something going on in our environment these days that's is triggering all sorts of autoimmune type, and, you know, don't ask me to go in,

345

346 No oo

12

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